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ABSTRACT

This compilation presents background information and a resource directory concerning the growing dilemma of crack-exposed infants. Information on the incidence of crack use among women of child-bearing age is reviewed. The effects of crack on young children are outlined, and ways in which parents, educators, and other professionals can help these children towards a normal lifestyle are explored. The document includes a glossary, a list of possible effects of prenatal exposure to cocaine and alcohol, prevention strategies, intervention strategies, treatment and rehabilitation approaches, the role of the school in working with substance-abused children, a description of a model program, a reprint of selected pages from a report of the Hillsborough County (Florida) Public Schools titled "Strategies for Teaching Young Children at Risk and/or Prenatally Exposed to Drugs," and a reprint of "Today's Challenge: Teaching Strategies for Working with Young Children at Risk due to Pre-natal Substance Exposure" prepared by the Los Angeles (California) Unified School District. The following types of resource information are provided in an appendix: (1) a list of state and territorial resources in the areas of drug abuse and mental health; (2) toll-free drug hotline numbers; (3) a list of federal agencies; (4) a list of national organizations; and (5) a list of information services with toll-free telephone numbers. Includes approximately 50 references. (JDD)

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Crack/Cocaine: An Overview and Directory

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Crack/Cocaine: An Overview and Directory

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Introduction/Background

Research indicates that as many as 375,000 crack exposed infants are born yearly (Krantowitz, Wingert, Pena, Gordon, & Padgett, 1990).

Ann-Marie Trotter, Program Director of Generations, an out patient treatment program for chemically dependent women and their infants, noted characteristics of crack exposed infants. They include; developmental lags, severely impaired speech such as limited vocabulary and difficulties in stringing words together, hyperactivity, as well as painfully stiff joints due to extreme muscle tension resulting in rigidity of movement (1990).

Statement of Problem

Teachers are in need of information that will assist them in dealing with this severe problem. The purpose of this project is to gather resources that will be compiled into a directory for teachers and others who are confronted with this growing dilemma.

Rationale/Purpose

Crack has been in existence for the last ten years. Crack knows no boundaries of its users, but is becoming prevalent among women of child bearing ages. We are producing a new generation of drug exposed infants with still unknown long term effects (Ann-Marie Trotta, 1990). Besharov (1989) notes that in just the past three years, parental addiction to crack has become one of the toughest problems that child welfare agencies are faced with. Each year, hundreds of children nationwide are dying and thousands are becoming permanently disabled due to the effects of crack. This investigation will assess the effects of crack on young children, how and where we as educators, parents, and other professionals can help these children to lead them on their way towards a normal lifestyle.

Definitions

Apnea

A temporary suspension of breathing.

Bonding

The process by which an infant develops a sense of trust and attachment to a consistent caregiver, is essential for healthy psychological development.

Child Abuse

This term refers to situations in which a child's physical, mental, and emotional well-being is harmed or threatened with harm by the acts or omissions of a parent, other person responsible for the child's welfare or institutional staff. (Hot Topics: Usable Research)

Child Protective Investigator

The department's authorized agent located in each district within the state and responsible for conducting child protection investigations of allegations that children have been abused or neglected by a parent or other person responsible for their welfare or institutional staff. (Hot Topics: Usable Research)

Cocaine

It is a short-acting, powerful central nervous system stimulant that is extracted from the South American cocoa bush. The cocaine (cocaine hydrochloride) available in this country is a pure white crystalline powder combined with adulterants added to stretch the supply and increase the seller's profit. Talc, flour, laxatives, sugar, and local anesthetics are just a few of the additives used to cut cocaine.

Crack

It is the street name which is given to freebase cocaine that has been processed from the cocaine hydrochloride to a base. This process uses ammonia or baking soda and water and heats the cocaine hydrochloride (Cocaine Freebase", 1986).

Drug Abuse

The intake of a chemical substance taken or administered under circumstances and at dosage levels which significantly increase the hazard potential whether or not the drug is used therapeutically, legally or as prescribed by a physician.

Drug Addiction

The resulting effect of drug abuse which produces both

physical dependence and drug tolerance. When the drug is abruptly discontinued, withdrawal symptoms are recognizable, and increased doses of the drug are required to produce the original effects of the drug.

Drug Tolerance

Development of body or tissue resistance to the effects of a drug so that larger doses are required to reproduce the original effect.

Drug Use

The intake of a chemical substance. The effects of which can be realized with minimal hazard potential regardless of whether or not the substance is used therapeutically, legally, or prescribed by a physician.

Harm to Children

This term includes, but is not limited to an injury of a newborn infant evidenced by that infant's being born physically dependent on certain controlled drugs and actual or potential failure of a parent to supply a child with adequate food, clothing, shelter, supervision or health care, although financially able or offered financial or other means to do so. (Hot Topics: Usable Research)

High Risk

In relation to prenatal substance exposure, a "high-risk" or "at-risk" child means a preschool child who:

- is a victim or a sibling of a victim in a confirmed or indicated report of child abuse and neglect.
- is a graduate of a perinatal intensive care unit.
- has a parent or guardian who is developmentally disabled, severely emotionally disturbed, drug or alcohol dependent, or incarcerated and who requires assistance in meeting the child's developmental needs.
- has no parent or guardian.
- is drug exposed. (Hot Topics:Usable Research)

Hydrocephaly-(Hydrocephalus)

A condition characterized by an abnormal increase in the amount of fluid in the cranium, causing enlargement of the head, wasting away of the brain, and loss of mental powers.

Learning Disabilities

Children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. Such disorders include such conditions as

perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

PCP (Phencyclidine)

It is a synthetic drug first developed as an anesthetic agent for surgery in the 1950's. Today there is no legal use for PCP. PCP is notorious for its variety of effects and for its unpredictability, acting at different times as a stimulant, depressant, or hallucinogen. PCP comes in several different forms in its original as a white or yellowish-white powder, as a tablet, or as a capsule.

(Hot Topics: Usable Research)

Physical Dependence

Dependence of body tissues on the continued presence of a drug as revealed by disturbing or life-threatening withdrawal symptoms which develop when the drug is discontinued.

Psychological Dependence

A tendency or craving for repeated or compulsive use, not

necessarily abuse, of an agent because its effects are deemed pleasurable or satisfying.

Public Law 94-142 (PL94-142)

Public Law 94-142 is the Education For All Handicapped Children Act of 1975. This law requires states to provide by September 1, 1978, a free appropriate education for all handicapped children between the ages of 3 and 18.

Public Law 99-457 (PL99-457)

Public Law 99-457 amended the Education of the Handicapped Act (PL94-142). This law mandated comprehensive multidisciplinary services for infants and toddlers (birth through age 2) and their families.

RADAR

Regional Alcohol and Drug Awareness Resource

Withdrawal Symptoms of Cocaine

Cessation of use by psychologically dependent users may lead to severe depression, collapse from exhaustion, severe cramping of the abdominal muscles, symptoms resembling asthmatic attacks and changes in brain wave patterns.

Placenta

A vascular organ within the uterus, connected to the fetus by the umbilical cord; it serves as the structure through which the fetus receives nourishment from, and the circulatory

system of the mother.

Overview

Ruth Kaminer (1990), Associate Director of Medical Services at the Kennedy Center, Jacobi Hospital, Bronx, New York, stated the effects of this drug are not really known as of yet. The problems that these children encounter could be generated by the following which is common among crack users: low socioeconomic status, lack of prenatal care, and use of other drugs.

The majority of crack exposed babies are born normal looking. Some of the characteristics of these children include: excessive crying, difficulty in controlling and comforting these children, tendency not to want to cuddle with others, tremors, less of an ability to adapt to various situations, inability to regulate their own state, tendency to tune out stimuli that would be appealing to others, smaller head circumference, decreased birth weight and being born prematurely.

Premature birth is likely because crack is a stimulant and when used late in one's pregnancy, it restricts the muscles inside the woman's abdomen causing premature birth. Many crack addicts desire their pregnancies to be shortened and therefore take crack to

induce labor. The result of this is many more premature newborns in intensive care units in hospitals.

After birth, about 50 to 75 percent of these babies go home with their mothers or a relative and up to 50 percent of these children go into foster care. Some of the crack exposed children are placed into emergency placements or group homes and few babies have been adopted (Kusserow, 1990).

Dr. Kaminer (1990), along with other physicians and researchers feels that preventing these women from using this and other drugs is most important. There needs to be extensive programs for the public along with informational materials available about the harmful effects of this drug. The state and local government should develop guidelines and training for child welfare staff, establish reporting and tracking systems and encourage outreach and community involvement with extensive campaigns that discuss the dangers of drug use.

Community and religious groups should become involved in identifying and helping mothers and children who are at risk. It is important to work with local black and Hispanic leaders. Crack addicted mothers and their babies need early intervention programs, health

care counseling, drug rehabilitation programs and parenting classes (Kusserow, 1990).

The effects of crack are frightening. Many women are selling their bodies for drugs which results in them having more children. When asked why they do not use contraceptives, one woman's answer was that she did not want to put any artificial pills into her body. These crack addicted women are not competent parents and often do not feel any allegiance towards their children. All they seem to care about is drugs. Other consequences of this drug is that crack abusing mothers engage in high risk sexual behavior and are bearing AIDS infected babies (Kusserow, 1990).

Other results from crack, as Dr. Kaminer (1990), points out, include high blood pressure, which can result in a stroke, and a weakening of heart muscles.

What Is Crack?

Crack refers to the crackling sound that is heard when the mixture is heated which is due to sodium bicarbonate ("Cocaine Freebase", 1986). Udell (1989) discusses the way crack is made. He states that addicts simply mix water, bicarbonate of soda, and cocaine hydrochloride powder into a paste. It is then dry heated to form a hard substance called "rock", which is ready to be smoked. Crack is being marketed in small vials, folding papers, or foil packets, usually containing one to four pellets (Cocaine/Crack, 1989). Each vial containing four pellets averages about twenty-five dollars (Morley, 1989).

Crack tends to be extremely addicting due to the rapid high followed by a profound low, leaving the user craving more of the drug. Morley (1989), a Washington editor of the Nation, decided that he wanted to experience first hand the high crack cocaine gives people in order to write about it. He states that one experiences a pleasure both elusive and powerful, along with feeling spaced and intense. One gets a sense that

the world looks just fine and that reality is not real at all.

Morley (1989), noted that the high lasted about twenty minutes followed by a chemical aftertaste that was present in his mouth. He stated there is a likelihood that one would have a desire to smoke another rock at that point.

Udell (1989) mentions that cocaine was first banned in the United States in 1914 at which time it was legally classified as a narcotic. Dr. Udell states that this drug is still used as a local anesthetic, even though it presents serious risks.

Prevalence

According to the National Institute on Drug Abuse, cocaine use has increased dramatically in recent years and has now reached epidemic proportions. In New York City, drug abuse, primarily crack, was responsible for a 72 percent increase on reports of child abuse between 1985 and 1988.

The first exposure of cocaine was back in the late 1800's. Widespread use emerged again in the 1950's and late 1960's which was a period in time when many drugs reached tremendous proportions. Today's epidemic is by

far the largest. Casual cocaine use is declining, but addiction is on the rise. This is especially true of women of child bearing age.

Finnegan (1990) mentions that substance abusing women more likely come from homes where their parents were either drug or alcohol dependent. Finnegan also notes, as does Trotta (1990), that these women had childhoods which included sexual abuse, physical abuse and extreme neglect.

Recent reports state that many crack users are increasingly combining crack with the hallucinogenic drug phencyclidine (PCP) which is called space base. Mixing this drug with crack has proven to be deadly (Cocaine/Crack 1989).

Koppelman and Jones (1989) also report that young children are entering the drug business because it is so profitable, and soon fall prey to its violence. It is believed that addicts need to smoke the rocks, which cost between ten dollars and thirty-five dollars a piece, so often that they could easily spend over \$1,000 daily to support their habits.

Crack can cause a physical and emotional addiction and causes a harmful chemical change in your

brain which leads to an intense craving for the drug.

Yoast (1990) notes that dependency comes very quickly and often people do not realize they are becoming dependent upon the drug. When someone is dependent upon crack, their whole life changes with often the following results: lower grades, family and friendships falling apart, loss of the ability to think clearly and behave properly, as well as poor health. Crack addicts need money to support their habit and this may result in stealing from others or selling drugs themselves.

Many of these noted effects may not be the result of withdrawal, but may instead result from continued exposure to the drug. Some effects lasted a few weeks and perhaps indicate a longer lasting central nervous system change, and not a pattern of withdrawal.

The Brazelton Neonatal Behavioral Assessment Scale shows depressed interactive abilities and poor state control in cocaine exposed infants, when compared to drug-free infants the same age.

A measure that is used beyond the newborn stage is the Movement Assessment of Infants. This measures motor development of full-term cocaine-exposed infants at four months of age (Schneider, Griffith, Chasnoff, 1989).

Many of the results noted on the Brazelton test are still evident at four months of age, when measured by the Movement Assessment of Infants. Certain abnormalities are still evident up to eight months later. Some effects have been lessened, but are indeed still present.

Poor state control changes in cocaine exposed infants, create behavioral problems for the babies and their care givers. For example, when these babies go from a deep sleep to screaming, it puts a damper on the interactions between the infant and the care giver.

Drug-free infants can make a smooth transition from one state to another. They can go from a sleep state to a quiet cooing state and enjoy the fruits of interaction. Four patterns are commonly observed in cocaine exposed infants. The first is a very deep sleep from which they do not wake, even when handled. The second is agitated sleep as shown by whimpering and being startled. The third is moving quickly from crying to sleeping. The last of these patterns is a panicked awake state (Schneider, Griffith, Chasnoff, 1989). All of these behavioral patterns make it difficult for the infant to bond successfully with their care giver. Abilities to respond to auditory and visual stimuli is very limited

because these children cannot maintain a state of alertness. Placing so much strain on the interactions between infant and mother, affects the type of care the baby will receive. This is a serious problem because the interactions, if positive, could greatly help the child's recovery, the lack of which may also increase the risk of physical child abuse.

Normal motor development includes kicking, flexing, reaching out, and exploration of knees and feet. These are all very important contributions to body image development. Cocaine exposed children have less apparent motor behaviors. They lie extended, have stiff and jerky movements, and present tremors in their upper extremities. These tremors impact on the baby's eye-hand coordination and less body exploring is evident. These body exploring skills are important for later environmental exploration. The stiff and extended reactions also impede the development of balance control. According to Dr. Evelyn Davis, a pediatrician at New York's Harlem Hospital, crack is creating children with global delays (1990). Global delays are another way of saying developmental problems. These problematic areas consist of walking, talking, socializing, erratic

behavioral disorders such as extreme hyperactivity, an inability to understand what is being said, poor expressive language and possible symptoms of autism and mental retardation. Pre-school educators from facilities such as Head Start, are calling to say that these children are very difficult, and difficult at best. They are extremely hard to manage and will require special education services later on. Along with developmental delays are a multitude of medical problems. These children will need small classes, specially trained educators, social workers, and psychologists.

Cocaine is a stimulant and causes increased heart rate, high blood pressure, seizures, brain hemorrhages, cardiac arrest, and death. Most vulnerable to these affects are the unborn children of women who are addicted to the drug. The rise in blood pressure caused by prenatal exposure can cause intrauterine growth retardation and the decreased blood supply and may lead to mental retardation or cerebral palsy. This is most likely to occur in the third trimester of the pregnancy when brain growth occurs.

Cocaine and crack can be passed from mother to newborn via breast feeding. Although long-term effects

are not yet known, what is known is that this drug can cause the baby to be irritable, tremulous and possibly develop high blood pressure and convulsions. The neurological effects are more likely a result of the drug itself, rather than from a withdrawal of the drug. There is some evidence that crack and cocaine exposed babies will improve as the drug is cleared from their systems. A smaller head size is also a possibility and this puts the baby at risk for cerebral palsy, mental retardation, dyslexia, learning problems, and hyperactivity. Another possible symptom is a poor quality of play. Crack exposed babies will hit and throw their toys, rather than holding a doll and combing her hair. Dr. Chasnoff and Dr. Howard are among the nation's experts on crack exposed babies. After various studies, they found that four or five weeks after birth many of these infants become physically rigid, which lasts up to several days (Blakeslee, 1989).

Koppelman and Jones (1989) discuss the effects of crack which include overcrowding of prisons, drug treatment centers, hospitals, and child welfare agencies.

The Center for Disease Control (CDC) blames sexual promiscuity which is associated with crack sales and use

for the recent surge of cases of syphilis and warns that this behavior will accelerate the spread of acquired immune deficiency syndrome (AIDS) in heterosexuals.

Chira (1990) mentions that regardless of these characteristics these drug-exposed students have the ability to learn in school and can lead either normal or close to normal lives if they receive help at an early age. Unfortunately, many school systems including New York City have no specific programs for these children.

POSSIBLE EFFECTS OF PRENATAL EXPOSURE TO COCAINE:

In the fetus:

- Miscarriage
- Premature labor
- "Abruptio placentae"
- Cerebral stroke
- Stillbirth delivery

In the infant:

- Low birthweight
- Small head circumference
- Impaired motor development
- Seizures and strokes
- Abnormally formed internal organs
- Rapid respiratory and heart rate
- Irritability
- Frequent startles
- Hypertonicity
- Unresponsiveness
- Tremulousness
- Difficulty in being comforted
- Irregular sleeping patterns
- Poor feeding patterns
- Abnormal sucking and swallowing
- Disorientation
- Frequent gaze aversion
- Atypical motor development
- Poor interactive capacities
- Alterations in bonding and attachment
- Increased risk of child abuse and neglect
- Increased risk of Sudden Infant Death Syndrome (SIDS)
- Increased risk of AIDS and syphilis (from mother)

In the child:

Impaired play skills	Irritability
Small head circumference	Speech and language delays
Impaired ability to concentrate	Poor task organization and processing difficulties
Impaired social skills	Problems related to separation and attachment
Difficulty coping with an unstructured environment	Motor development delays
Impulsivity and hyperactivity	
Heightened response to internal and external stimuli	
Tremors	

POSSIBLE EFFECTS OF PRENATAL EXPOSURE TO ALCOHOL:

In the fetus:

Miscarriage
Premature labor
Stillbirth delivery

In the infant:

Low birthweight

Fetal Alcohol Syndrome, including:

- 1) growth retardation before and/or after birth
- 2) a particular pattern of abnormal features of the eyes, face and head, including small head circumference (suggesting diminished brain growth), small eyes, and evidence of a retarded formation of the midfacial area including a flattened bridge and short length of nose and flattened vertical groove between the mouth and nose
- 3) evidence of central nervous system abnormality

Fetal Alcohol Effects, like:

Physical deformities
Heart defects
Ear and eye defects
Joint and limb malformations
Mental retardation
Cerebral palsy
Neurological abnormalities
Hemangiomas
Irritability
Sleep problems
Impaired motor development; poor locomotion
State regulation disorders
Increased risk of child abuse
Sucking and feeding difficulties
Response inhibition

In the child:

Hyperactivity
Reduced body weight, height and head circumference
Facial abnormalities
Mild hearing loss
Development delays

Attention deficit disorder syndrome, expressed as restlessness, short attention span, distractibility, longer reaction time
Learning difficulties

The Pregnant Drug Addict and Her Baby

During pregnancy, the drug passes into the placenta and can stay in the fetus up to three hours after ingestion by the mother. How is she to cope with mood swings of her own as well as those of her addicted new-born? Does the screaming and listlessness of the infant contribute to the ingredients of child abuse? Hopefully these ingredients can and will be prevented by treating both addicts at once. Once the mother receives support and treatment, she can recognize what has happened to her baby as a result of her drug use! (Brazelton, 1990).

Cocaine easily crosses over from the placenta to the fetus. The drug can remain in the fetus' circulation long after being excreted from the mother. The fetus' liver and kidneys are too immature developmentally to metabolize the cocaine. This will now penetrate into the central nervous system of the developing fetus. Cocaine is water soluble so it will not pass back into the mother's system in order to be excreted. It may well be ingested by the fetus via the amniotic fluid (Besharov, 1989).

Pinpointing the specific effects of crack exposure is often difficult, due to the fact that many drug abusing mothers abuse other drugs as well. The infant's future environment will also impact on later development (Besharov 1989).

Crack use early in the mother's pregnancy can cause miscarriages or stillborns. Sometimes, when the drug causes the placenta to separate early, the lives of the mother and baby are in danger due to bleeding and shock (Cocaine/Crack, 1989).

"The following characteristics are drawn from studies of highly impoverished, substance-abusing pregnant women:

- Most have a history of physical, sexual, or emotional abuse.
- They have the disease of chemical dependency and need treatment.
- Their mothers and fathers probably abused alcohol and other drugs.
- They are likely to live with a drug-using partner.
- They may come from the poorest, most deprived, most chaotic environments.
- They feel guilty and responsible for their plight.

-Their orientation to life is often characterized by low self-esteem and powerlessness.

-Denial is part of their disease process. They tell themselves "a little won't hurt," or "I'll do it just once more".

-Blaming, reprisals, and attempts to criminalize them keep them from using systems and services that could help.

-Their ability to be a good parent is compromised by their disease of chemical dependency and the often difficult behavioral characteristics of their infants.

(Hot Topics: Usable Research)

According to Dr. T. Berry Brazelton, (1990), Americans have become numb to the hopelessness of their children. Approximately one million teenagers become pregnant each year, and about 18 percent of the newborns in city hospitals are born addicted to alcohol and crack. In cases of impoverished families, these children have many health problems and not enough health care. Prenatal care is not a factor in poor families as a group. However, in the case of crack, economic boundaries no longer exist. This is steadily becoming a middle-class and affluent problem in the 90's.

Many or most of the women who use crack never see the inside of a hospital until they are in labor. We as a society have a responsibility to prevent these crack addicted babies from becoming statistics. We need to prepare these children to contribute in a positive manner to society. There is little commitment to family issues today. As educators, we must strive to change that attitude. We need to educate society, parents, children, and all professionals dealing with human resources. Brazelton (1990) reports that a chance encounter with a homeless man, led to a discussion about his television show on parenting. Apparently, this man had an infant, and when he could, he watched the show with great interest. The man explained to Dr. Brazelton that he applied his new-found skills, along with his wife, in the street; their home. Basically, the point was that people we may view as not interested may very well turn out to be exceptional parents, if given the opportunity. Training and support could probably do much more than society would choose to believe. Lets take the time to care enough and build a family around children who are needy. We must not let them give up.

Thornton (1989) writes that there are hundreds of

border babies born to drug-addicted mothers in the city. These babies must go through a long procedure before leaving the hospital. First the doctors have to make sure the infants are medically fit to leave. Next, the city needs to make sure that the families are also fit, being able to provide proper care. In nearly half of these cases, the families are found unfit and the lengthy search for foster care begins.

While the babies stay in the hospitals, the personnel do not have the time to give the much needed love and cuddling to these babies. St. Lukes-Roosevelt Hospital Center has developed a program for these infants called Baby Holders. This program involves various volunteers such as lawyers, retirees and computer experts to list a few. These people feed, sing to, play with, and provide the much needed love to these border babies.

The cost of treating crack babies is more than seventy five million dollars annually (Howse, 1989). Both crack and cocaine can be deadly drugs. Cocaine is a stimulant drug and it is a powder taken from a cocoa leaf. Crack is a form of cocaine which has been chemically changed so that it can be smoked. Sometimes

crack comes in small pieces that look like shavings of soap (Yoast, 1990). Crack is also called rock since it looks like a rock. Crack costs about twenty-five dollars for a rock which can be split up into four or five smaller rocks as Morley (1989) discusses.

It is believed that babies born to addicts wait at least a month to be discharged. Many babies get cleared to leave the hospital but have no place to go. These children are basically healthy, clean, and detoxified but still in need of a great deal of love and hugs.

Another problem facing these children is that drug use is still a factor in their homes. Doctors believe that these youngsters may be seriously injured by breathing the crack filled smoke in their homes.

Jing Ja Yoon, chief of neonatology at Bronx Lebanon Hospital, points out these mothers do not care about their babies or themselves. She cites a case of neglect of a ten month old crack baby by its mother. This mother left her child alone overnight in an overheated room which reached 110 degrees while she visited her boyfriend. Yoon states that she has never seen mothers like this before as does Ms. Linda Spooner who is director of a drug treatment center setup in New York's

Jamaican community and who has been in this business for twenty years. She writes that she has never seen a drug destroy a person as quickly as crack does.

"Drugs per se never account for all the phenomena we attribute to them. Rather, the social and economic circumstances and the history of the individual drug user powerfully determine the outcome of drug use, and the characteristic pattern of drug addiction" [p.44] (Drucker, 1990). Instead of concentrating on the chemical of crack, we should delve into why a person uses crack and what preceded the drug use. Crack reaches the brain quicker than most other drugs and disappears just as rapidly. More and more crack is needed to sustain the highs and avoid the lows. Unfortunately, many of the crack users today are either pregnant women, or women with children. No one is absolutely positive though that the use of crack is the sole cause of fetal damage that may occur, or if it is in conjunction with other factors such as intergenerational poverty, inadequate prenatal care, or the results of environmental disadvantages of the society they live in (Drucker, 1990).

When these women seek treatment, it is obvious that society is prejudiced to this group, and offers

inadequate services if any at all. A few model services are available to pregnant women who are addicted to crack (Drucker, 1990). These centers are available without the threat of placing children into foster care at the onset of their treatment. This premise could insure more women coming forward for treatment, which would drastically reduce the long term problems associated with use throughout the entire pregnancy. Perhaps instead of looking toward institutionalized care for crack-exposed infants, we should utilize the mothers in the crucial role of family supporter in conjunction with helpful community services, in order to sustain healthy families, both physically and emotionally.

Strategies for Prevention

Prevention is the key to treating this problem. Education is crucial through the media, schools, and health care professionals. As educators and other professionals who dedicate our lives to children, we must try to protect these babies. Children born to addicted mothers need a protected environment, as they are at high risk of neglect and abuse. This drug undermines maternal instincts, which leads to abandonment and detachment. Mother-infant bonding is prevented and the child is at risk of becoming emotionally depressed. There could also be a lack of bonding due to the irritable state of the infant. The mother may not be able to cope with the child, which would further complicate the bonding process. We need to provide positive role models for these mothers, possibly through counseling and or support groups.

Prevention and early intervention is essential in treating these drug-exposed babies and their mothers. It is highly likely that early intervention, coupled with proper infant stimulation, may provide positive results for these children.

Blakeslee (1989) discusses the conclusion of studies which suggest that pupils of addicted mothers may, without help, be unable to develop into adults with basic employment skills and would be unable to form close human relationships.

Prevention

Money alone cannot solve the nations pressing drug and alcohol problems. Ultimately, the efforts of concerned teachers, parents, youth, and other citizens will turn the tide of alcohol and other drug problems. Individuals working and volunteering their time and energy because of an overriding concern for the health, safety, and welfare of the members of their communities have developed some of the most promising approaches to this problem.

Four categories were developed which address alcohol and drug problems which include: prevention, intervention, treatment, and aftercare.

Prevention must be applied to society as a whole in an attempt to develop a climate where: illegal drugs are not used at all, abusive substances like gasoline and aerosol propellants are only used for their intended purposes, over the counter and prescription drugs are

used only for their intended purposes, and where alcohol use is only acceptable for those of legal age.

Intervention strategies have been developed which are directed towards people who have started experiencing problems as a result of drug use. The major goal of early intervention strategies is to reduce the amount of use and to prevent this use from progressing further.

The third category in dealing with today's drug problem is treatment. This is provided to people who exhibit severe problems as a result of their drug use and who are addicted to or dependent upon drugs.

Finally, aftercare of rehabilitation is the last strategy which must be applied to drug users. After an individual becomes alcohol or drug free they require programs that help them return to society free of destructive patterns that made treatment necessary.

Recently, prevention programs have focused on attempting to teach life skills, such as coping skills, decision making skills, communication skills, and skills to resist peer and other social pressures to use alcohol and other drugs. These programs try to enhance self-esteem giving these users techniques which make them feel good about themselves without using drugs.

Other frequently used prevention strategies utilized include alternative programs. These programs include providing alternative highs or adventures, opportunities for meaningful involvement such as community service programs, and opportunities for alcohol and other drug free recreation such as prom week celebrations.

Prevention strategies which focus on the family encourage parents to reduce their own alcohol and other drug use and to avoid involving their children in related behaviors like opening beers, lighting cigarettes, and pouring drinks. Finnegan (1990) mentions that comprehensive, family-oriented treatment is necessary. These women have extremely low self esteem and need to build their confidence and self-respect in order to conquer this chronic relapsing disease. Programs for these women must include high-risk prenatal care, and must be staffed with obstetricians who are specifically trained in the area of addiction and high risk pregnancy. These treatment programs must include individual, group and family therapy.

Other prevention techniques focus on altering the norms of peer groups through publicity campaigns that promote positive health messages, peer leadership

training, clubs, and organizations which are devoted to promoting no-use lifestyles.

Since for most Americans, alcohol and drug use peaks during early adulthood (18-25 years of age) there has been an increase in concern over the use of drugs on college campuses. Various student groups have sponsored campaigns that raise awareness of the dangers of these drugs.

There are various organizations which are actively, involved in trying to reduce the nations alcohol and drug problems. These agencies develop prevention materials, conduct national media campaigns, disseminate programs, lobby for alcohol and drug abuse legislation, and provide training and technical assistance. Various organizations include schools, physicians, nurses, other health care professionals, and religious institutions.

Ultimately, prevention of this drug and alcohol problem relies upon the efforts of ordinary citizens (Citizen's Alcohol and Drug Prevention Directory, 1990).

According to Besharov (1989) it is believed that money for prevention techniques should be spent on things such as: pre-school programs, better education, expanding Headstart Programs, job training, and better housing

conditions in general. In order to accomplish this, government and community leaders need to make sure that drugs and pregnancy do not mix. Despite what is known about the harmful effects of cocaine, the government has not tried to educate young women about the dangers of drug use during pregnancy. Education is needed and it could be through schools or through the media. Another recommendation focuses on the fact that legal power along with financial resources must be given to hospitals to care for drug exposed babies. They should be given enough resources allowing them to medically and socially care for these babies properly until they are ready to be discharged. Another suggestion which tries to protect drug affected children is that adoption must be a real option for babies whose parent shows little prospect for improvement. Many of these children are placed in foster care and are not put up for adoption because the hope is that one day they would be reunited with their parents. These babies deserve a chance and most are adoptable (Besharov, 1989). A fourth solution is to develop a chemical block for this drug. New York City's Health Commissioner, Stephen Joseph, feels that a methadone-like treatment to diminish the craving for crack is

needed and that this must become a national biomedical research priority (Howse, 1989). A final recommendation that was made by Howse is to expand and evaluate acupuncture programs. Studies at Lincoln and Kings County hospitals dealing with acupuncture detoxification programs are encouraging, but not conclusive, and more studies must be performed. Many drug treatment programs do not offer help to pregnant addicts. One program now addressing this issue is the Perinatal Center for Chemical Dependence in Chicago. The staff provides prenatal and postnatal care and infant care. Education is emphasized including Lamaze, nutrition, family planning, parenting as well as women's issues and the law. (Schneider, Griffith, Chasnoff, 1989).

Strategies for Intervention

Early intervention is a term used for discovering that a child between birth and school age has, or is at risk of having, a handicapping condition or other special need that may interfere with development (Kirk and Gallagher, 1989). It also includes providing services to the child and his/her family to lessen the effects of the condition. Evidence from research indicates that intervening early in a child's life increases developmental and educational gains of the child, improves the functioning of the family, and in many cases, makes children either at risk or already having a handicapping condition, indistinguishable from non-handicapped peers. The purpose of early intervention is to provide children with early positive stimulation and provide them with an opportunity to learn (Kirk and Gallagher, 1989). Providing early stimulation can keep learning problems from getting larger as a result of not receiving the necessary emotional, social and pre-academic services at-risk children desperately need.

Programs such as Head Start can be a good place to

start with early intervention techniques, but the staff need to be specifically trained to deal with drug-exposed children and their special needs. These children require special care in all aspects such as holding when they are infants, feeding, boarding, playing, and when they are approaching school age, need help with socialization and pre-academics. These children can greatly benefit from specific play techniques taught early, when they are at their personal peak of learning.

Parents need to be taught to recognize the area of concern at a very early age. The problem is that most of the mothers of drug-exposed babies are not in the proper state of mind to care for either themselves, or their children. Many are still on drugs and are not receiving help for their addiction. Many children are left in hospitals and/or placed in foster care and do not receive the proper intervention techniques required to help them overcome their serious afflictions after drug withdrawal at birth. Education for parents and professionals is the key ingredient necessary to help those children.

The passage of P.L. 99-457 in 1986 created a system of services for at risk and handicapped children. This law provides that early intervention services will yield

substantial benefits for these children and their families. The main crux of P.L. 99-457 is its focus on family involvement, and states that successful intervention requires meaningful parent-professional partnerships (Kirk and Gallagher, 1989). A broader understanding of parents and their lives will improve their ability, and the abilities of professionals, to cope with the disabilities of the child and this will lead to better interaction between parent and child. Built into the framework of P.L. 99-457, is the Individual Family Service Plan which provides the educational and developmental framework for services provided for at-risk and handicapped children. By enhancing parenting skills, we can enhance the level of confidence with which the parents deal with parent-child relationships (Guralnick, 1989). Efforts to build family strength and competence may provide the essential ingredients to successfully nurture a drug-exposed child and enhance the effectiveness of early intervention.

Many researchers see preschool educational programs as a vehicle to prepare children for the learning and living that lie ahead (Sava, 1989). Such things as structural play should be seen as serious learning.

One specific problem that crack-exposed children face is the inability to play. They do not play appropriately with toys, choosing rather to throw them across the room (Kantrowitz, Wingert, Pena, Gordon, and Padgett, 1990). Educators see playing skills as a means of motivating young learners to develop a positive attitude toward learning. Special needs children need to learn about themselves and the skills they possess, before ingesting education as adults perceive it. Playing helps to develop a curiosity about the child and his/her environment. Failure to master skills such as walking, hopping, skipping, or cutting with scissors, can indicate later developmental delays which can impact on later learning. If these babies do not receive the proper instructions very early on, the long term problems may be more serious than was first believed.

We also need to make programs such as Head Start and Chapter 1, available to the families of drug-exposed children. Project Head Start provides developmental services to low-income pre-school children. Head Start brought attention to early childhood development and provided models for training child-development personnel. They use an interdisciplinary approach which combines

emotional, social, health, nutritional, and psychological services ("Betting on Winners" 1987).

Head Start employs parental and community involvement, making the program successful as well as cost effective. Parents learn about their child's needs, and are taught activities that can be done at home. Head Start also provides health care, including medical, dental, mental health, and nutritional services.

Programs such as Head Start and Chapter 1 compensate for disadvantages of low-income children resulting from economic status. If these were made available to drug exposed children and their families, we would have an additional outlet for people who otherwise might be left untreated. These programs deal with children from three to five years of age and choose them according to the severity of their needs. This is where early assessment and screening would be beneficial.

Chapter 1 is a federally funded program that provides newly-entered elementary students with extra help to avoid falling behind in school. Many of the drug exposed children being born, will not have detectable problems until they reach school age where expectations increase in terms of demonstrating their acquired skills,

or lack thereof. Each program and activity addresses the problems of these children. These provided and needed opportunities can translate into gains when detected early and are properly dealt with, before the problems become too large. We must draw on community involvement and resources for comprehensive and effective services for at-risk children who are bound for problems. Early identification and early assessment may help to reduce the long-term effects of prenatal exposure to crack and lead these children to more productive lives.

According to Brazelton (1990), we must intervene to prevent losing both the addicted mother as well as their crack addicted baby. Help must come not in the form of a band-aid, but it must be available all of the time. Family and individual needs must be addressed and met. The staff giving help must be properly trained and society as a whole must be behind it. We must nurture the people who nurture our children. Research indicates that one hit of crack can damage a developing fetus.

Parents must give their child respect, love and the discipline they need to respect drugs and become mature, healthy, confident adults. Parents must teach them to say no to drugs. Remember to be a good role model since your

children are always watching you (The New Jersey Dept. of Health in Conjunction with Fred J. Goldstein, Ph.D).

Arthur is an example of a child who was attending an intervention program in a special school in Houston, Texas for crack babies. He was adopted by his aunt who states that Arthur was so wild it was as though he was possessed. At first, he would not let his teacher come closer than eight feet before he would begin throwing toys at her. After two years in this program, Arthur made little progress. He is now able to walk calmly holding his aunt's hand which he was not able to do when he first entered the program (Kantrowitz, Wingert, Pena, Gordon, and Padgett, 1990).

Thus far, there are very few programs to help these children. It appears that early intervention seems to be crucial. In one program at the Salvin Special Education School in Los Angeles, there are eight three and four year old children in each class with three teachers. The school day is filled with regular preschool activities such as songs, games, and art projects. The school also has social workers, psychologists, pediatricians, and speech and language specialists (Kantrowitz, Wingert, Pena, Gordon, and Padgett, 1990).

Our society is now acknowledging drug abuse. It is extremely important for all health care professionals to gather information regarding development after prenatal exposure. They also need to begin interventions that will aid these exposed infants and their care givers (Besharov, 1989).

Intervention techniques should allow proper infant and care-giver interaction. These activities should concentrate on making the bonding process more easily accessible.

Specific laying positions can improve both posture and movement patterns in a cocaine exposed infant. Laying on one's side can help to overcome increased extensor tone and the effects of gravity. Proper physical therapy techniques and spinal supports can maintain posture and still allow for movement. These techniques can help increase a relaxed behavioral state.

Proper and loving handling of these infants is another crucial aspect. The care-giver should not be afraid of irritating the baby by picking him up. Handling is essential in order to improve motor skills and state control. Being wrapped in a warm blanket, slow rocking and proper handling can facilitate movement and

calmness in the infant. It can reduce crying, irritability, and increase state control.

These positive results encourage better interaction between the infant and the care giver. The use of hydrotherapy is also used to improve motor skills and reduction of irritability. The baby is put into a tub of 99 degree water and it has been found to improve posture, muscle tone, behavioral states, and feeding patterns (Schneider, Griffith, Chasnoff, 1989). Eventually these techniques should be reduced to encourage the infant to gain control of their own state. These handling and positioning techniques also aid feeding patterns by improving extensor tone, posture, behavioral states of calmness, visual alertness, and improved sucking behaviors.

Educating parents is a vital phase of the intervention process. Parent education includes teaching appropriate play, handling and carrying techniques, which vary with the infant's needs. Demonstrations of techniques as well as follow up visits to the home are crucial and are needed to facilitate proper bonding. The baby must be taught to move appropriately through their environment. This has a positive effect on psychosocial

and cognitive development. Parents can be taught how to move their baby and play so as to facilitate proper movement and development. The infant can be encouraged to move by placing colorful objects next to them in order to prompt them to turn and reach. Parents need to become familiar with the developmental needs of their children. This will aid in the recognition of the child's needs as well as their progress. Making the daily interactions easier, will help to improve the long range bonding between mother and child and the child's environment. Experience has shown that many of these difficulties can be ameliorated with proper intervention strategies (Schneider, Griffith, Chasnoff, 1989).

Treatment and Rehabilitation

More crack addicts are taken by the "instant gratification" they attain from the drug. Their environments, in many cases, provide little or no pleasure for them. They in turn, go for the quick gratification of crack, which is also affordable, in the beginning! For many people, their role models are young people with fancy cars, jewelry and clothes, and that along with the danger in attaining all of this, adds a flavor of excitement and desire. Many of the crack users at treatment centers were themselves victims of neglect or abuse, they possess few social and verbal skills, are less tolerant of frustration, and are quick to resort to violence. The values of abstinence, impulse control and deferred gratification are unreal in the world of crack (Morley, 1990).

Recovery demands a fundamental renovation of personal values and self-image. The addict needs to totally change their lifestyle and abstain from drugs completely. Recovery means transformation, taking up a new life, new values and new goals in a moral and psychological rebirth (Morley, 1990). Statistics show

that there are more female crack addicts than there are males. The traditional drug treatment centers are designed specifically for men, and do not address the special needs of women. One of these special needs is being pregnant, or already having children. Many women also do not seek treatment for fear that their children will be taken away (Morley, 1990). Hemphill (1990) mentions that of the twenty-six state-funded residential treatment facilities in New York City, twenty-two reject pregnant females stating that they are not equipped to work with these women. Of the 5,232 residential beds in New York City for drug addicts, only four pregnant women are enrolled in programs.

In order to gain admission to New York City's Phoenix House, a counselor for the Community Family Planning Council in Brooklyn told a patient she was working with to hide her pregnancy in order to gain admission. Unfortunately, once the agency found out that the woman was pregnant, she was refused admittance.

At Montefiore Medical Center in the Bronx, New York, Dr. Ernest Drucker, along with the Ackerman Institute, received a 3.5 million dollar grant from the Federal Government to help female crack addicts and their

children. This program views the addict's family as a healing resource and they try to help these people develop a new sense of self outside of the family. Their feeling is that female addicts do not need to separate from the family, but instead, need to repair the damaged connections. By improving relationships with their children, as well as their own mothers, they can develop a better sense of value and self-esteem to help get them off drugs (Morley, 1990). The goal of the Montefiore/Ackerman Project is to raise the self-esteem of the female and strengthen the bond between the addict and her child. This will hopefully decrease the number of children requiring Foster Care placements (Morley, 1990).

America's crack problem is getting worse and worse. We need treatment programs for mothers which could protect their babies (Kantrowitz, Wingert, Pena, Gordon, and Padgett, 1990). Treatment for a crack addict without assistance is difficult. There are many treatment programs which can help the addict get off and stay off of the drug. The programs include: detoxification, ridding the body of the drug, and sometimes followed by medication such as antidepressants to help in controlling

the craving and severe depression which often occurs when withdrawing from crack. Supportive family members and friends along with counseling can help to make recovery a success (Cocaine\Crack", 1989).

Drug abuse in the United States is on the rise. Each year there are more drug-exposed infants being born. There is now a growing need for prevention, treatment, and rehabilitation strategies for addicted females and their children. There is a need for further research, as professionals are now faced with the task of identifying the services that will prevent and remediate this social tragedy.

Treatment and Teaching Strategies

"Experts suspect that our educational system already contains significant numbers of substance-exposed children. Because these children are of normal intelligence, however, the subtle deficits affecting their performance may remain undetected. Early research with substance-exposed preschoolers, the oldest group of children being followed by researchers, shows they are unable to function effectively in a traditional school setting. Thus, without assistance, substance-exposed children appear to be at great risk for school failure and for dropping out of school.

Yet the proper school setting can make a great difference in the lives of children affected by their parents' substance abuse. Structure, consistency, and concern are important components of this optimal learning environment, along with a good deal of individualized attention. Teachers who work with substance-exposed children must be familiar with related neurological impairments that affect learning and behavior. Rather than working in isolation, they must also be willing to work as part of a multidisciplinary team. In model early

intervention programs, the first substance-exposed children under study are responding to such an approach by learning and growing." [p.35] (Harpring, 1990).

Listed below are some suggestions for people who work with crack exposed children:

- 1) There needs to be a means for early identification by working with child welfare agencies in the communities to identify crack affected children.
- 2) Lobby for funds to begin programs to help these drug exposed children from birth to three years old and beyond.
- 3) Make sure to educate students through drug education programs which teach pupils the skills they need to resist drug use. Since about one million teenagers become pregnant each year and do not realize that crack is bad for them and their babies. This education is essential.
- 4) Make sure appropriate classroom environments exist for these pupils which include:
 - allowing the student to remain with the same teacher for more than one year
 - reduce fragmentation
 - cutting down on classroom interruptions

- emphasizing routines, rituals, and schedules
- finding ways to make school less stressful, less demanding, and more predictable
- 5) Call for more research since little data exists on the long-term effects of prenatal cocaine use (Rist, 1990).
- 6) Class rules should be limited, allowing children to explore and actively engage their environment.
- 7) Transition from one activity to another should be seen as an activity. Since changes in activities can upset these children, setting off tantrums, teachers give these students ample warning when changing activities- both verbally and with music. (Chira, 1990)
- 8) Provide predictable classroom routines and rituals
- 9) Ratio of adults to pupils should be small enough to promote nurturing and allow children to become attached to the adults in the program.
- 10) Class environment must be flexible. Teachers must be able to remove objects which are distracting for the pupils.
- 11) Continuity in program staff with no one appearing or disappearing without explanation.
- 12) Teachers need to accept their students and the

feelings that they have whether they appear negative or positive. Time needs to be allowed for the students to discuss their feelings.

13) Close contact with the student's home is imperative to find out what may be troubling a child and also to support the parent (Viadero, 1989).

14) Many researchers who work with these children believe that they should be placed in regular programs as opposed to giving them labels which will be with them forever (Chira, 1990).

Since the students require stability, the routine is unwavering. The same adults are involved day after day. Back rubs and hugs are provided after, and instruction can take a back seat to esteem building. At a school in Fort Lauderdale, Florida for these children, teachers call attendance even though it is obvious everyone in the tiny class is present just so the children have a chance to shout out "Here, present" (Marks, 1990).

The Salvin Institute (see Appendix B), which is a school in California for drug exposed students does the following:

-Pupils are guided through transitions by verbally walking them through changes, having them hold hands and

help each other, responding to their tears with reassurance and closely following routines.

-Each pupil works with the same teacher for a two year period and the same teaching assistants and support team for one year (Laderman, 1990).

Another aspect of teaching strategies deals with the families of drug addicts. Many of these family members are grandparents who already raised their own children, only to find themselves raising their grandchildren. Reluctantly, many begin child-bearing all over again in their fifties or sixties. This happens in lieu of foster care placements for these children whose parents are impaired by drug use. Families are being torn apart by this problem and everyone becomes a victim. The one common thread here is that all of the victims need to be supported in some way, and to be kept from being isolated. The grandparents need love and support as well as understanding for the sacrifices they have made for their grandchildren. The children on the other hand, need love and nurturing as well as specialized school techniques to be able to deal with their handicaps and their emotional baggage. If the grandmother gets a hug or a smile from the child, she may feel that all of this

was worth it. If, on the other hand she receives little or no help and support from friends, family members or public agencies, it may appear enough to make her give up (Buchanan & Lappin, 1990). Many of these grandparents also feel guilty about their own children's plight as well as feelings of ambivalence toward raising their grandchildren. If these feelings are not dealt with properly, angry reactions could then be directed toward the child. Along with the ambivalent feelings of the adults, are those of the child toward his/her mother and grandmother. They worry about the drug killing their mother, about the bad feelings they have about having been beaten by their parents, about not having someone to care for them if their grandmother dies, and they cannot enjoy being a child. This is a heavy burden for a young child to cope with. We can easily see how families struggle with this problem. We can also see how these feelings and worries can exacerbate negative behaviors in this situation.

At the University of Pennsylvania, Bruce Buchanan and Jay Lappin direct "The Grandparents Project." The center helps to create a relationship between the clinician and the grandparent, which acts as a role model

for the relationship between the grandparent and the child (Buchanan & Lappin, 1990). This atmosphere helps to encourage the ability to keep the family together in order to obtain positive results for all concerned. Creating an atmosphere of love and happiness will help keep the families together and stable. The therapist must utilize the strengths of the family to create a healthy bond between its' members (Buchanan & Lappin, 1990).

Appendix A

States and Territories

1) Alabama

-The number to call in Alabama for a referral to a helping agency for drug abuse is (205)270-4650

-Prevention Coordinator
Alabama Department of Mental Health
2 Interstate Park Avenue
Montgomery, AL 36193-5001

-State Education Agency
Drug-Free Schools Coordinator
607-A State Office Building
Montgomery, AL 36130
(205)261-5252

-North Alabama Substance Abuse Council
Cullman County Courthouse
Prevention Coordinator
Room 22
Collman, AL 35055
(205)739-3533, ext. 203

2) Alaska

-The number to call in Alaska for referral to a helping agency for drug abuse is (907)561-4213

-RADAR of Alaska
Alaska Council on Prevention of Alcohol + Drug Abuse, Inc.
Executive Director
7521 Old Seward Highway
Suite B
Anchorage, AK 99518
(907)349-6602

-State Education Agency
Drug-Free School Coordinator
P.O. Box F
Juneau, AK 99811-0500
(907)465-2841

-National Federation of Parents
Alaskans for Drug-Free Youth
Director

P.O. Box 8515
Ketchikon, AK 99901
(907) 247-2273

-National Council on Alcoholism
Alaska Council on Prevention of Alcohol + Drug Abuse
Director
7521 Old Seward Highway
Suite A
Anchorage, AK 99518
(907) 349-6602

-Community Counseling Program
Kuskokwim Native Association
Program Director
P.O. Box 155
Aniak, AK 99557
(907) 675-4445

-Mental Health/ Substance Abuse Services
Copper River National Association Executive Director
Mile 104 Richardson Highway, Drawer H
Cooper Center, AK 99573
(907) 822-5241

-City and Borough of Juneau
Alcohol + Drug Abuse Central Agency
Chemical Dependence Administrator
3406 Glacier Highway
Juneau, Ak 99801
(907) 463-3008

3) Arizona

-The number to call in Arizona for referral to a helping agency for drug abuse is (602) 220-6478

-Prevention Program Representative
Office of Community Behavioral Health Services
41 North 24th Street
Phoenix, AZ 85008
(602)220-6478

-Regional Center for Drug- Free Schools and Communities
Coordinator
1700 West Washington

Room 810
Phoenix, AZ 85007
(602) 542-3456

-Arizonans for Drug-Free Youth
Director
P.O. Box 62433
Phoenix, AZ 85082-2422

-Association of Alcohol, Drug Abuse, and Mental Health
Treatment Programs
Director
1700 North 7th Avenue, Suite 112
Phoenix, AZ 85007
(602) 937-9203

-Governor's Alliance Against Drugs
Director
Capitol Tower, Room 810
1700 West Washington
Phoenix, AZ 85007
(602) 542-3456

4) Arkansas

-The number to call in Arkansas for referral to a helping
agency for drug abuse is (501) 682-6656

-RADAR for Arkansas
Clearinghouse Coordinator
Division of Alcohol + Drug Abuse Prevention
400 Donaghey Plaza North
P.O. Box 1437
Little Rock, AR 72203-1437
(501) 882-6553

-Department of Education
Drug- Free Schools Coordinator
Arch Ford Education Building
Capital Mall
Little Rock, AR 72201
(501) 682-4475

-National Federation of Parents
Arkansas for Drug-Free Youth
Director

311 North Elm Street
Little Rock, AR 72205
(501)664-7865

5) California

-The number to call in California for referral to a helping agency for drug abuse is (916) 445-0834

-State Prevention Coordinator
California Department of Alcohol + Drug Programs
111 Capitol Mall
Sacramento, CA 95814
(916) 445-1125

-RADAR for California
Drug Program Analyst
State of California Department of Alcohol + Drug Programs
111 Capitol Mall
Room 250
Sacramento, CA 95814
(916) 324-7234

-State Education Agency
Drug-Free Schools Coordinator
P.O. Box 944272
Sacramento, CA 94244-2720
(916) 322-4018

6) Colorado

-The number to call in Colorado for referral to a helping agency for drug abuse is (303) 331-8201

-Colorado Association of Professionals in Prevention/Intervention/Treatment
Addictions Research and Treatment Service
Director
University of Colorado Health Sciences Center
3738 West Princeton Circle
Denver, CO 80236
(303) 761-2885

-Southwest Regional Center for Drug-free Schools
and Communities
Director
4670 MacArthur Drive
Boulder, CO 80303
(303) 866-6865

-Prevention Resource Center
250 Arapahoe Avenue
Suite 301
Boulder, CO 80302
(303)443-5696

-Communities for a Drug-free Colorado
Director
140 East 19th Avenue
Suite 100
Denver, CO 80203
(303)894-2750

-Alcohol + Drug Education and Prevention Training
Director
Department of Community Health
University of Northern Colorado
Greeley, CO 80639
(303) 351-1335

-Parenting as Prevention
Director, ADAD
4210 East 11th Street
Denver, CO 80220
(303) 331-8212

7) Connecticut

-The number to call in Connecticut for referral to a
helping agency for drug abuse is (203) 566-4145

-Prevention Coordinator
Connecticut Alcohol + Drug Abuse Commission
Prevention Division
999 Asylum Avenue
Hartford, CT 06105
(203) 566-7458

-Connecticut Communities for Drug-free Youth

Director
156 South Avenue
New Canaan, CT 06840
(203) 972-3234

-State Education Agency
Drug-free School Coordinator
P.O. Box 2219
Hartford, CT 06145
(203) 566-2931

8) Delaware

-The number in Delaware for referral to a helping agency
for drug abuse is (302) 571-6975

-Governor's Drug Abuse Coordinating Council
Carvel State Office Building
820 French Street
Wilmington, DE 19801
(800) 292-9570 (toll-free; DE only)
(302) 571-3210

-Neighborhood House, Inc. WCASA
1218, B Street
Wilmington, DE 19801
(302) 652-3928

9) Columbia

-The number to call in Columbia for referral to a helping
agency for drug abuse is (202) 727-0660 or (202) 783-
1300

-District Office of Drug Control Anti-Drug Czar
1111 E Street, NW
Washington, DC 20004
(202) 724-9474

-D C Public School Substance Abuse Prevention Program
Lovejoy School
12th and D Streets, NE
Washington, DC 20012
(202) 724-3610

10) Florida

- The number to call in Florida for referral to a helping agency for drug abuse is (904) 488-0900
- State Education Agency
Drug-free School Coordinator
Education Prevention Center
Knott Building
Tallahassee, FL 32399-0444
(904) 488-6304
- Florida Alcohol and Drug Abuse Association
1286 North Paul Russell Road
Tallahassee, FL 32301
(904) 878-2196
- Florida Informed Parents for Drug-free Youth, Inc.
2334 Capital Circle, NE
Tallahassee, FL 32308
(904) 385-7641

11) Georgia

- The number to call in Georgia for referral to a helping agency for drug abuse is (806) 338-6745
- Georgia State Board of Education
Drug-free Schools Coordinator
Health and Physical Education
1952 Twin Towers East
Atlanta, GA 30334-5040
(404) 656-2414
- Families in Action National Drug Information Center
3845 North Druid Hills Road, Suite 300
Decatur, GA 30033
(404) 325-5799
- Statewide Minority Advocacy Group for Alcohol + Drug Prevention
c/o Georgia Mental Health Institute
1256 Briarcliff Road, Room 216-E
Atlanta, GA 30306
(404) 894-8671

12) Guam

-The number to call in Guam for referral to a helping agency for drug abuse is [(671)646-9261 through 9269].

-National Federation of Parents for Drug-free youth
Department of Mental Health + Substance Abuse
P.O. Box 9400
Tamuning, Guam 96911
(671) 646-9260

13) Hawaii

-The number to call in Hawaii for a referral to a helping agency for drug abuse is (808) 537-1678

-Coalition for a Drug-Free Hawaii
547 Halekauwila Street #109
Honolulu, HI 96815
(808) 942-3786

-Just Say No
1750 Kalskaua Avenue
Honolulu, HI 96815
(808) 942-3786

14) Idaho

-The number to call in Idaho for referral to a helping agency for drug abuse is (208) 334-5935

-Idaho State Department of Education
Drug-free Schools Coordinator
Len B. Jordan Building
650 West State

15) Illinois

-The number to call in Illinois for referral to a helping agency for drug abuse is (312) 782-0686

-Illinois Drug Education Alliance
P.O. Box 159
Carlinville, IL 62626
(217) 854-8472

-Central State Institute of Addictions
721 N. La Salle Street
Chicago, IL 60610
(312) 266-6100

16) Indiana

-The number to call in Indiana for referral to a helping agency for drug abuse is (312) 232-7818

-National Federation of Parents
Indiana Federation of Communities for Drug Free Youth
39 Boone Village
Zionsville, IN 46077
(317) 873-3900

-Department of Education
Drug Free Schools Coordinator
Center for School Improvement
State House
Room 229
Indianapolis, IN 46204-2798
(317) 232-9114

17) Iowa

-The number to call in Iowa for referral to a helping agency for drug abuse is (515) 281-3641

-Iowa Network of Drug Information
National Federation of Parents
314 E. Ayers Street
Asceola, IA 50213
(515) 342-4304

-Iowa Substance Abuse Information Center
500 1st Street, SE
Cedar Rapids, IA 52401
(319) 752-7076

-Substance Abuse Treatment Unit of Central Iowa
Prevention Specialists
19 West State Street
P.O. Box 1453
Marshalltown, IA 50158
(515) 752-5412

18) Kansas

-The number to call in Kansas for referral to a helping agency for drug abuse is (913) 296-3925.

-Kansas Department of Education
Drug-Free Schools Coordinator
120 E. 10th Street
Topeka, KS 66612
(913) 296-6714

-Toward a Drug-Free Kansas Initiative
Governor's Special Assistance on Drug Abuse
State Capitol
Topeka, KS 66612-1590
(913) 296-2584

-Kansas School Team Training for Substance Abuse
Prevention
U.S.D. 259
Substance Abuse Prevention Office
217 N. Water
Wichita, KS 67202
(316) 833-2303

19) Kentucky

-The number to call in Kentucky for referral to a helping agency for drug abuse is (800) 432-9337.

-State Education Agency
Drug-Free Schools Coordinator
Capitol Building
Frankfurt, KY 40627
(502) 564-2611

-Congress of Parents + Parents (PTA)
Drug and Alcohol Chairperson
66 Fountain Place
Frankfurt, KY 40601
(502) 564-4378

-Prevention Coordinator
Family Alcohol + Drug Counseling
7103 Turfway Road
P.O. Box 1034

Florence, KY 41042
(606) 283-9222

20) Louisiana

na for referral to a
-The number to call in Louisiana is (504) 342-9350
helping agency for drug abuse

-State Education Agency
Drug-Free Schools Coordinator
P.O. Box 94064
Baton Rouge, LA 70804-9064
(504) 342-3473

-Hammond Alcohol + Drug Abuse Center
100 Medical Arts Plaza
Hammond, LA 70403
(504) 549-3975

-River Parishes Alcohol + Drug Abuse Center
Route 1
Box 17-B
Lutcher, LA 70071
(504) 869-5723

21) Maine

for referral to a helping
-The number to call in Maine is (800) 322-5004
agency for drug abuse

-RADAR for Maine
Maine Alcohol + Drug Abuse Warehouse
Office of Alcoholism + Drug Abuse Prevention
State House Station #11
Augusta, ME 04333
(207) 289-2781

-Aroostook Alcohol + Drug Abuse Council, Inc.
Masonic Building, Room 14
Market Square
Houlton, ME 04730
(207) 532-7858

-Division of Alcohol + Drug Education
Department of Educational and Cultural Services
State House #57

Augusta, ME 04333
(207) 289-6500

22) Maryland

-The number to call in Maryland for referral to a helping agency for drug abuse is (301) 224-6873

-Alcohol + Drug Abuse Administration's
Office of Education + Training for Addiction Services
201 West Preston Street
4th floor
Baltimore, MD 21201
(301) 225-6933

-State Education Agency
Drug-Free Schools Coordinator
200 West Baltimore Street
Baltimore, MD 21201
(301) 333-2318

-Substance Abuse Education + Prevention Program
Morgan State University
202 Carter Grant-Wilson Building
Hillen Road + Cold Spring Lane
Baltimore, MD 21239
(301) 444-3043/3133

23) Massachusetts

-The number to call in Massachusetts for referral to a helping agency for drug abuse is (800) 327-5056

-Alcohol + Drug Abuse Association
59 Temple Place, Suite 508
Boston, MA 02111
(617) 451-0155

-Freedom from Chemical Dependency (FCD)
26 Cross Street
Needham, MA 02194
(617) 444-6969

-Governor's Peer Leadership Council
c/o Governor's Alliance Against Drugs
1 Ashburton Place

Room 2131
Boston, MA 02108
(617) 727-0786

24) Michigan

-The number to call in Michigan for referral to a helping agency for drug abuse is (517) 335-8831

-Office of Drug Agencies
Grandview Plaza Building
P.O. Box 30026
Lansing, MI 48909
(517) 373-4700

-Institute of Alcohol + Drug Dependency
Marsh Hall 301C
Andrews University
Berran-Springs, MI 49103
(616) 471-3558

-Northern Michigan Substance Abuse Services, Inc.
1723 West M-32
Suite A
Gaylord, MI 49735
(517) 732-1791

-South Central Michigan Substance Abuse
Commission
Jackson Tower Building
120 West Michigan Avenue, Room 904
Jackson, MI 49201
(517) 788-4400

25) Minnesota

-The number to call in Minnesota for referral to a helping agency for drug abuse is (612) 296-3991

-Institute on Black Chemical Abuse
2614 Nicollet Avenue South
Minnesota, MN 55408
(612) 871-7878

-Drug Information Service
3-160 Health Sciences

308 Harvard Street, SE
Minneapolis, MN 55455
(612) 624-6492

-State Education Agency
Drug-Free Schools Coordinator
300 Centennial Building
658 Cedar Street
St. Paul, MN 55155
(612)296-8415

26) Mississippi

-The number to call in Mississippi for referral to a helping agency for drug abuse is (601) 359-1288

-Mississippi Department of Mental Health
Division of Alcoholism + Drug Abuse
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39207
(601) 359-1288

-State Education Agency
Drug-Free Schools Coordinator
550 High Street
P.O. Box 771
Jackson, MS 39205
(601) 359-3598

27) Missouri

-The number to call in Missouri for referral to a helping agency for drug abuse is (314) 751-4942.

-State Education Agency
Drug-Free Schools Director
P.O. Box 480
Jefferson City, MO 65102
(314) 751-5386

-Community Crusade Against Drugs
11947 Glen Oaks Drive
Maryland Heights, MO 63043
(314) 739-8710

-Council for Drug-Free Youth
113-1/2 West High Street
Jefferson City, MO 65101
(314) 636-2411

-National Council on Alcoholism + Drug Abuse- Kansas City
Area
601 East 63rd Street
5th floor
Kansas City, MO 64110
(816) 361-5900

-National Council on Alcoholism + Drug Abuse- St. Louis
Area
8790 Manchester
St. Louis, MO 63144
(314) 962-3456

28) Montana

-The number to call in Montana for referral to a helping
agency for drug abuse is (406) 444-2827

-Prevention Coordinator
Department of Institutions
1539 11th Avenue
Helena, MT 59620
(406) 444-2878

29) Nebraska

-The number to call in Nebraska for referral to a helping
agency for drug abuse is (402) 471-2851

-Nebraska Prevention Center for Alcohol + Drug Abuse
University of Nebraska
218 Coliseum
Lincoln, NE 68588
(402) 472-6046

-Nebraska Coalition for Prevention of Drug Problems
215 Centennial Mall South
Room 412
Lincoln, NE 68508
(402) 474-0930

-State Education Agency
Drug-Free Schools Coordinator
P.O. Box 94987
(402) 471-2783

30) Nevada

-The number to call in Nevada for referral to a helping agency for drug abuse is (702) 885-4790

-Bureau of Alcohol + Drug Abuse
628 Belrose Avenue
State Mailroom Complex
Las Vegas, NV 89158
(702) 486-5250

-Nevada Department of Education
Education Consultant for Prevention of Alcohol + Drug Abuse
400 West King Street
Carson City, NV 89710
(702) 885-3104

-Nevada Bureau of Alcohol and Drug Abuse
505 East King Street
Capitol Complex
Carson City, NV 89710
(702) 885-4790

-Northern Area Substance Abuse Council
320 Flint Street
Reno NV, 89501
(702) 786-6563

-Northern Nevada Hispanic Substance Abuse Prevention Program
P.O. Box 11735
Reno, NV 89510
(702) 786-6803

31) New Hampshire

-The number to call in New Hampshire for referral to a helping agency for drug abuse is (800) 852-3345. ext. 4628.

-State Education Agency
Drug-Free Schools Coordinator
State Office Park South
101 Pleasant Street
Concord, NH 03301
(603) 271-3494

-New Hampshire State Clearinghouse for Substance Abuse
Information
P.O. Box 157
Atkinsen, NH 03811
(603) 898-1516

-RADAR for New Hampshire
New Hampshire Office of Alcohol and Drug Abuse
Prevention
6 Hazen Drive
Concord, NH 03301
(603) 271-4638

32) New Jersey

-The number to call in New Jersey for referral to a
helping agency for drug abuse is (800) 322-5252

-RADAR for New Jersey
New Jersey Alcohol/Drug Clearinghouse
129 East Hanover Street
Trenton, NJ 08625
(609) 292-4414, 292-0729

-Governor's Council on Alcoholism and Drug Abuse
C/O Department of the Treasury
State House
CN002
Trenton, NJ 08625
(609) 633-6911

-New Jersey Association for the Prevention and Treatment
of Substance Abuse
73 Green Street
Woodbridge, NJ 07095
(201) 634-7910

-Substance Abuse Treatment Providers, Inc.
75 Washington Street

Mount Holly, NJ 08060
(609) 726-7155

-New Jersey College Consortium on Substance Abuse
Education
129 East Hanover Street
Trenton, NJ 08625
(609) 292-0729

-National Federation of Parents
New Jersey Federation for Drug-Free Communities
P.O. Box 702
Livingston, NJ 07039
(201) 325-1398

33) New Mexico

-The number to call in New Mexico for a referral to a
helping agency for drug abuse is (505) 256-8300

-State Prevention Coordinator
HED/BHSD/ Substance Abuse Bureau
1190 St. Francis Drive
Santa Fe, NM 87503
(505) 827-2589

-New Mexico Department of Education
Education Building
Drug-Free Schools and Communities
300 Don Gaspar
Santa Fe, NM 87501-2786
(505) 827-6635

-New Mexico Citizen's Council on Alcoholism and Drug
Abuse
7711 Zuni Place SE
Albuquerque, NM 87108
(505) 265-6811

-Parents for Drug-Free Youth
P.O. Box 3510
Albuquerque, NM 87190
(505) 299-9426
(800) 423-8686 (toll free in NM only)

34) New York

-The number to call in New York for referral to a helping agency for drug abuse is (800) 522-5353

-Generations
220 Ferris Avenue
White Plains, New York 10603
(914) 761-4245

-New York State Division of Substance Abuse Services
Deputy Director for Substance Abuse Prevention
Executive Park South
Box 8200
Albany, NY 12203
(518) 457-2963

-Anti-Drug Abuse Council
State Capitol
Second Floor
Albany, NY 12224
(518) 474-4615

-Citizens Alliance to Prevent Drug Abuse
36 West Main Street
Executive Office Building
Rochester, NY 14614
(716) 454-1650

-New York State Association of Drug and Alcohol
Prevention and Education Professionals
47 Cornell Road
Latham, NY 12210
(518) 786-3211

-New York City Substance Abuse Prevention Network in
Schools
c/o School District 23
2240 Dean Street
Brooklyn, NY 11233
(718) 495-7701

-Commission of Drug and Alcohol Abuse
157 East 72nd Street
New York, NY 10021
(212) 988-3959

-State Education Department

Bureau of Health and Drug Education
Washington Avenue
Albany, NY 12234
(518) 474-1491

-New York State Division of Substance Abuse Services
Regional Supervisor
Regional Office 7A
55 West 125th Street
New York, NY 10027
(212) 870-8422

-National Council on Alcoholism and Other Drug
Addictions/ Westchester
360 Mamaroneck Avenue
White Plains, NY 10605
(914) 683-1213

-Alcohol and Drug Abuse Council of Orange County, Inc.
26 St. John Street
Goshen, NY 10924
(914) 294-9000

-National Council on Alcoholism and Other Drugs
2 Church Street
P.O. Box 688
Carmel, NY 10512
(914) 225-4646

-Sullivan County Council on Alcoholism and Substance
Abuse, Inc.
17 Hamilton Avenue
Monticello, NY 12701
(914) 794-8080

-Dutchess County Council on Alcoholism and Chemical
Dependency, Inc.
20 Maple Street
Poughkeepsie, NY 12601
(914) 471-0194

-Mohawk Valley Council on Alcoholism/Addictions
42 Genesee Street
New Hartford, NY 13413
(315) 732-6155

-Ontario County Council on Alcoholism and Other Chemical
Dependencies of the Finger Lakes, Inc.
500 Hamilton Street
Geneva, NY 14456
(315) 789-0310

35) North Carolina

-The number to call in North Carolina for referral to a
helping agency for drug abuse is (919) 733-4670

-Department of Public Education
Division of Alcohol & Drug Defense
210 North Dawson Street
Raleigh, NC 27603-1712
(919) 733-6615

-Alcohol/Drug Council of North Carolina
P.O. Box 25111
Durham, NC 27702
(919) 688-7058

-Drug Information Center
2809 Industrial Drive
Raleigh, NC 27609
(919) 832-4453

37) North Dakota

-The number to call in North Dakota for referral to a
helping agency for drug abuse is (800) 642-6042 (toll
free in ND only)

-North Dakota State Department of Health & Consolidated
Laboratories
Health Planning Administration
State Capitol
Bismarck, ND 58505
(701) 224-2894

-Heartview Foundation
Adolescent Treatment Director
1406 NW 2nd
Mandan, ND 58554
(701) 663-2321

38) Ohio

-The number to call in Ohio for referral to a helping agency for drug abuse is (614) 466-3445

-Ohio Association of Parents for Drug-Free Youth
712 Glenshire Avenue
Cincinnati, OH 45226
(513) 352-2842

-Alcohol & Drug Abuse Prevention Association of Ohio
P.O. Box 15175
Columbus, OH 43215
(614) 645-6256

-Association of Ohio Substance Abuse Programs
Route 2, 2357 Horning Road
Shelby, OH 44857
(419) 683-3711

39 Oklahoma

-The number to call in Oklahoma for referral to a helping agency for drug abuse is (405) 271-8755

-State Education Agency
Drug-Free Schools Coordinator
2500 North Lincoln Blvd.
Oklahoma City, OK 73105-4599
(405) 521-2106

-The Oklahoma Alliance Against Drugs
4545 North Lincoln Boulevard
Oklahoma City, OK 73103
(405) 524-6223

40 Oregon

-The number to call in Oregon for referral to a helping agency for drug abuse is (800) 621-1646

-Oregon Drug & Alcohol Information Center
235 North Graham
Portland, OR 97227

-Partnership for a Drug-Free America, Inc.

c/o Oregon Council of the American Association of
Advertising Agencies
Gerber Advertising
209 SW Oak Street
Portland, OR 97204
(503) 221-0100

-Oregon Federation of Parents For Drug-Free Youth
18818 SE Mildred
Milwaukee, OR 97030
(503) 655-4037

-Alcohol & Drug Information Service
P.O. Box 12547
Salem, OR 97309
(503) 378-8381

41 Pennsylvania

-The number to call in Pennsylvania for referral to a
helping agency for drug abuse is (800) 932-8912

-Governor's Drug Policy Council
Finance Building, Room 310
Harrisburg, PA 19120
(717) 783-8626

-Division of Student Services
Drug-Free Schools Coordinator
Bureau of Basic Education Support
333 Market Street
Harrisburg, PA 17126-0333

-RADAR for Pennsylvania
Office of Drug & Alcohol Programs
P.O. Box 90
Health & Welfare Building
Harrisburg, PA 17108
(412) 391-0900

42 Puerto Rico

-The number to call in Puerto Rico for referral to a
helping agency for drug abuse is (800) 462-4495

-Department of Education

Drug-Free Schools Coordinator
 P.O. Box 959
 Hato Rey, PR 00919
 (809) 758-4949, ext. 6047

-RADAR of Puerto Rico
 Department of Anti-Addiction Services
 Apartado 21414, Rio Piedras Station
 Rio Piedras, PR 00928-1414
 (809) 763-3133

43 Rhode Island

-The number to call in Rhode Island for referral to a helping agency for drug abuse is (401) 464-2191

-School-Support Services
 Drug-Free Schools Coordinator
 22 Hayes Street
 Providence, RI 02908
 (401) 277-2638

-Rhode Island Substance Abuse Coalition
 c/o United Way
 229 Waterman Street
 Providence, RI 02903
 (401) 521-9000

-Rhode Island Association of Substance Abuse Prevention Programs
 P.O. Box 327
 Greenville, RI 02828
 (401) 231-7932

-National Federation of Parents
 Rhode Islanders for Drug-Free Youth
 57 Gould Place
 East Greenwich, RI 02818
 (401) 464-2191

44) South Carolina

-The number to call in South Carolina for referral to a helping agency for drug abuse is (800) 942-3425

-Department of Education

Drug-Free Schools Coordinator
 Substance Abuse Education Unit
 1429 Senate Street
 Columbia, SC 29201
 (803) 734-8097

-RADAR for South Carolina
 The Drugstore Information Clearinghouse
 Clearinghouse Administrator
 South Carolina Commission on Alcohol & Drug Abuse
 3700 Forest Drive
 Columbia, SC 29210
 (803) 734-9559

-Charleston County Substance Abuse
 P.O. Box 2635
 25 Courtenay Drive
 Charleston, SC 29403
 (803) 723-7212

45 South Dakota

-The number to call in South Dakota for referral to a
 helping agency for drug abuse is (605) 793-3123

-State Education Agency
 Drug-Free Schools Coordinator
 Division of Education
 700 Governors Drive
 Pierre, SD 57501
 (605) 773-4670

46 Tennessee

-The number to call in Tennessee for referral to a
 helping agency for drug abuse is (800) 653-DRUG

-State Education Agency
 Drug-Free Schools Coordinator
 140 Cordell Hull Building
 Nashville, TN 37219
 (615) 741-7027

-Tennessee Alcohol & Drug Clearinghouse
 150 Venture Circle, #204
 Nashville, TN 37228

(615) 244-7066

-Region 2-A
Detox Rehabilitation Institute
6400 Papermill Road
Suite 100
Knoxville, TN 37919
(615) 584-1797

47 Texas

-The number to call in Texas for referral to a helping agency for drug abuse is (512) 463-5510

-Texans' War On Drugs
1104 Research Building B
Suite 200
Austin, TX 78759
(512) 343-6950

-Commission On Alcohol & Drug Abuse
1705 Guadalupe
Austin, TX 78701-1214
(512) 463-5510

-Texas Alliance of Councils on Alcoholism & Drug Abuse
103 South Travis
Sherman, TX 75090
(214) 892-9911

48 Utah

-The number to call in Utah for referral to a helping agency for drug abuse is (801) 538-3939

-Prevention Representative
Alcohol & Drug Abuse Clinic
50 North Medical Drive
P.O. Box 2500
Salt Lake City, UT 84132
(801) 581-6228

-State Education Agency
Drug-Free Schools Coordinator
250 East 500 South
Salt Lake City, UT 84111

(801) 538-7713

-Utah Federation of Parents For Drug-Free Youth
120 North 200 West, 4th Floor
Salt Lake City, UT 84103
(801) 538-3949

-Utah County Department of Substance Abuse
100 East Center Street
Suite 3200
Provo, UT 84601
(801) 370-8427

49) Vermont

-The number to call in Vermont for referral to a helping agency for drug abuse is (802) 241-2170

-RADAR for Vermont
Office of Alcohol and Drug Abuse Programs
103 South Main Street
Waterbury, VT 05676
(802) 241-2178

-State Education Agency
Drug-Free Schools Coordinator
Comprehensive Health Education
120 State Street
Montpelier, VT 05602-2703
(802) 828-3111

50) Virginia

-The number to call in Virginia for referral to a helping agency for drug abuse is (800) 451-5544

-Commonwealth Alliance for Drug Rehabilitation and Education
Office of the Attorney General of the Commonwealth
Supreme Court Building
101 North Eight Street
Richmond, VA 23219
(804) 225- 3373

-Alcohol & Other Drug Training Center
Virginia Commonwealth University

Division of Health & Physical Education
Box 2037
Richmond, VA 23284
(804) 367-1482

-Virginia Federation of Drug-Free Communities
7760 Shrader Road
Richmond, VA 23228
(804) 755-7015

-Eastern Shore CSB
Substance Abuse Director
P.O. Box 453
Nassawadox, VA 23413
(804) 787-7555

51 U.S. Virgin Islands

-The number to call in the U.S. Virgin Islands for
referral to a helping agency for drug abuse is (809)
773-4869

-RADAR for Virgin Islands
Division of Mental Health, Alcoholism & Drug Dependency
Services
P.O. Box 1117
St. Croix, VI 00821
(809) 773-8443

-State Education Agency
Drug-Free Schools Coordinator
44-46 Kogens Gade
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-4976

52) Washington

-The number to call in Washington for referral to a
helping agency for drug abuse is (800) 572-1240.

-Prevention/Early Intervention Administrator
Division of Alcohol and Substance Abuse
M.S. OB-44W
Olympia, WA 98504
(206) 753-3203

- RADAR for Washington
Washington State Substance Abuse Coalition
14700 Main Street
Bellevue, WA 98007
(206) 747-9111
- State Education Agency
Office of Superintendent of Public Instruction
Office of Physical Education and Health
Old Capitol Building, FG-11
Olympia, WA 98504
(206) 753-6752
- National Federation of Parents
Washington State Substance Abuse Coalition
14700 Main Street
Bellevue, WA 98007
(206) 455-1683

53) West Virginia

- The number to call in West Virginia for referral to a helping agency for drug abuse is (304) 348-2276
- State Education Agency
Drug-Free Schools Coordinator
Student Support Services
Capitol Complex, B-309
Charleston, WV 25305
(304) 348-7843
- Drug-Free Communities Program
Office of Community & Industrial Development
Drug-Free Communities Coordinator
5790A MacCorkle Avenue
Charleston, WV 25304
(304) 348-8814

54 Wisconsin

- The number to call in Wisconsin for referral to a helping agency for drug abuse is (608) 266-2717
- State Education Agency
Drug-Free Schools Coordinator
125 South Webster Street

P.O. Box 7841
Madison, WI 53707
(608) 266-3390

-Wisconsin Association on Alcohol & Other Drug Abuse
2801 West Beltline Highway, #235
Madison, WI 53713
(608) 273-8616

-Wisconsin Federation of Parents For Drug-Free Youth
P.O. Box 150
Mishicot, WI 54228
(414) 755-4516

55 Wyoming

-The number to call in Wyoming for referral to a helping agency for drug abuse is (307) 777-7115

-VINTA County Rehabilitation Center
305 Vinta View Drive
Suite 303
Evanston, WY 82930
(307) 789-3710

-Governor's Drug Policy Board
Division of Criminal Investigation
316 West 22nd Street
Cheyenne, WY 82002
(307) 777-7181

-Wyoming Department of Education
Drug-Free Schools Coordinator
Hathaway Building
Cheyenne, WY 82002
(307) 777-7673

Toll-Free Drug Hotline Numbers**For People Who Have Substance Abuse Problems**

- 1) National Toll-Free Drug Hotline
1-800-262-2463
100 Edgewood Avenue N.E. Suite 1002
Atlanta Georgia 30303
- 2) National Institute on Drug Abuse Hotline
1-800-662-HELP
5600 Fishers Lane
10A-54 Parklawn Building
Rockville, MD 20857
- 3) Drug-Free Workplace Helpline
1-800-843-4971
- 4) New Jersey Drug Hotline
1-800-225-0196
- 5) Division of Substance Abuse Services
1-800-522-5353
- 6) Seafield Drug Rehabilitation
1-800-448-4808
- 7) Runaway Hotline and Message Relay
1-800-231-6946
- 8) Drug Abuse 24 Hour Mental Health Helpline and Hospital
Referrals of Humanistic Foundation
1-800-333-4444
- 9) Haverstraw Narcotics Guidance Council
1-800-922-5535
- 10) North Shore Prevention Services
1-800-334-5512
- 11) Adolescent Substance Abuse Prevention
1-800-658-3597
c/o Jo Oihus, Networker
1169 Lookout Lane
Rapid City, SD 57701

12) National Institute on Drug Abuse
1-800-843-4971

13) Cocaine Baby Help Line (for pregnant woman)
1-800-638-BABY

Federal Agencies and the Services They Provide

- 1) Administration for Native Americans
200 Independence Avenue, SW
Room 344-F Hubert Humphrey Building
Washington, DC 20201
(202) 245-7776

This agency provides a comprehensive prevention approach to reduce drug abuse. A cultural approach aimed at traditional Native American practices is emphasized.

- 2) Bureau of Indian Affairs
Department of the Interior
18th + C Streets, NW
Mailstop 2620
Washington, DC 20240
(202) 343-1191

This agency provides prevention activities for tribal government bodies, reservations and villages.

- 3) Drug Enforcement Administration
Washington, DC 20537
(202) 307-7936

This agency provides guidelines for a drug-free workplace, guidebooks, workbooks for home and school and major strategies which are translated in Spanish.

- 4) Department of Education
Drug Abuse Prevention Oversight and Staff
Office of the Secretary
400 Maryland Avenue, SW
Washington, DC 20202-0120
(202) 732-3030

This agency provides training to schools and communities on effective prevention programs.

- 5) Federal Bureau of Investigation
Drug Demand Reduction Program

10th Street and Pennsylvania Avenue, NW
Washington, DC 20535
(203) 324-5611

This agency provides and disseminates pertinent drug demand reduction programs and makes public presentations on drug awareness.

- 6) Indian Health Service
Alcoholism and Substance Abuse Program
Room 6A-53
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4297

This agency provides activities designed to cultivate self-esteem, coping and decision making skills, family bonding, and effective parenting.

- 7) Department of Justice
Office of Justice Programs
633 Indiana Avenue, NW
Washington, DC 20531
(202) 724-7782

This agency developed Drug Abuse Resistance Education (DARE) which includes: DARE Curriculum, workbooks, films, videos, and handouts for students, teachers, and parents.

- 8) Office for Substance Abuse Prevention
ADAMHA/OSAP
5600 Fishers Lane
Rockwall II Building
Rockville, MD 20857
(301) 443-2467

This agency operates a prevention demonstration grant program, conducts prevention workshops and trains health care providers.

- 9) Office for Treatment Improvement
ADAMHA/OTI
5600 Fishers Lane
Rockwall II, Tenth Floor

Rockville, MD 20857
(301) 443-2467

This agency manages alcohol and drug abuse mental health block grants. In 1990, \$1.193 billion for grants was available.

- 10) Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420
(202) 233-5193

This agency provides inpatient detoxification and rehabilitation programs, outpatient treatment, methadone maintenance and family interventions.

National Organizations and the Services They Provide

- 1) American Association for Counseling and Development (AACD)
5999 Stevenson Avenue
Alexandria, VA 22304
(703) 823-9800

This organization provides prevention activities.

- 2) American Council for Drug Education (ACDE)
204 Monroe Street, Suite 110
Rockville, MD 20850
(301) 294-0600
Contact: Executive Director

This organization provides videos, films, discussion guides for parents, workplace drug awareness programs, school library kits, media kits, programs in substance abuse, and pregnancy programs for physicians and their patients.

- 3) American Indian Training Institute, Inc. (AITI)
4153 Northgate Boulevard
Sacramento, CA 95834
(916) 920-0731
Contact: Executive Director

This organization conducts prevention workshops for Indians and their communities.

- 4) Boys Club of America (BCA)
771 First Avenue
New York, NY 10017
(212) 351-5906

This organization offers drug-free alternatives to the streets with positive role models.

- 5) Boy Scouts of America (BSA)
1325 Walnut Hill Lane
P.O. Box 152079
Irving, TX 75015-2079
(214) 580-2000
Contact: Chief Scout Executive

This organization offers full color youth-oriented booklets about drugs, videos of superstars saying no to drugs, and a full color body chart that depicts the effects of drugs on the body.

- 6) Campuses Without Drugs, Inc.
National Office
2530 Holly Drive
Pittsburgh, PA 15235
(412) 731-8019

This organization provides information packets, articles, flyers, workshops, and posters.

- 7) Elks Drug Awareness Program
P.O. Box 310
Ashland, OR
(503) 482-3193

This organization provides prevention pamphlets, brochures, and pocketcards.

- 8) Girls Club of America, Inc.
30 East 33rd Street, 7th floor
New York, NY 10016
(212) 689-3700

This organization provides a peer-based approach to prevention education called Friendly Peersuasion.

- 9) "Just Say No" International
1777 No. California Blvd., Suite 210
Walnut Creek, CA 94596
(415) 939-6666
In Washington: (202) 452-7876

This organization provides young people with the information, skills, and support they need to resist influence of drugs and alcohol.

- 10) National Asian Pacific Families Against Substance Abuse, Inc. (NAPAFASA)
6303 Friendship Court
Bethesda, MD 20817
(301) 530-0945

This organization provides information and literature, educational materials, and films to be used among Asian Pacific American communities across the United States.

- 11) National Association On Drug Abuse Problems, Inc.
(NADAP)
355 Lexington Avenue
New York, NY 10017
(212) 986-1170

This organization provides training, literature, and referral information.

- 12) National Committee for the Prevention of Alcoholism and Drug Dependency
Route 1, Box 635
Appromattox, VA 24522
(804) 352-8100
(301) 680-6719: for information about attending workshops and seminars

This organization provides workshops, seminars, educational programs, prevention programs for the youth, visual and teaching aids, publications and relevant information.

- 13) National Council on Alcoholism and Drug Dependence, Inc. (NCADD)
12 West 21st Street
New York, NY 10010
(212) 206-6770
(800) NCA-CALL
(800) 622-2255

This organization provides public information, prevention and education programs.

- 14) National Drug Information Center of Families in Action
2296 Henderson Mill Road, Suite 204
Atlanta, GA 30345
(404) 934-6364

This organization provides publications of Drug Abuse Updates, treatment referral services, and parent and community group information.

- 15) National Federation of Parents for Drug-Free Youth
(NFP)
Youth Programs
14325 Oakwood NE
Albuquerque, NM 87123
(505) 294-2929

This organization provides programs for all aspects of society: government, parents, communities, corporations, and youth.

**Toll-Free Numbers for Information About Drugs, Prevention
Programs, Publications, and Education in This Area**

- 1) Drug Abuse Resistance Education (DARE AMERICA)
P.O. Box 2090
Los Angeles, CA 90051
1-800-223-DARE
- 2) Beginning Alcohol and Addiction Basic Education
Studies (BABES)
17730 Northland Park Court
Southfield, MI 48075
1-800-54-BABES

BABES is a division of the National Council on Alcoholism and Other Dependencies of Greater Detroit. BABES assists young children to develop positive living skills and provides them with accurate information about the use and abuse of drugs. Parents who want this training may take this sixteen hour course in good parenting skills which is taught through the use of puppets and story lessons.

- 3) Johnson Institute
7151 Metro Boulevard, Suite 250
Minneapolis, MN 55435
1-800-231-5165

Prevention is a major concern of the Johnson Institute. They provide curricula, publications, films, videos, and educational seminars that focus on prevention.

- 4) Narcotic Education, Inc. (NEI)
12501 Old Columbia Pike
Silver Spring, MD 20904
1-800-548-8700

This program provides prevention education services through materials for places of worship, offices, community organizations, schools, and districts.

- 5) National Clearinghouse (NCADI)

P.O. Box 2345
Rockville, MD 20852
1-800-SAY NO TO

This agency provides literature.

- 6) National Parents' Resource Institute for Drug Education (PRIDE)
1-800-241-7946

This is a telephone network which links parents and others to share information on drug abuse.

- 7) Northeast Regional Center for Drug-Free Schools and Communities
1-800-233-NERC

This agency provides information about drugs, prevention programs, high risk youth, and northeast regional center programs.

- 8) New Jersey Self-Help Clearinghouse
1-800-452-9790

- 9) Department of Housing and Urban Development's Office for Drug-Free Neighborhoods
1-800-666-3223

- 10) Cocaine Baby Helpline
1-800-327-BABE

Appendix B

The Role of the School

Chira (1990) predicts that in the near future some inner-city school drug exposed pupils will make up 40 to 60 percent of the school population.

The March of Dimes believes that the number of crack-exposed children could reach anywhere from half a million to four million by the year 2000.

Doctors monitoring cocaine births believe that in the mid-1990's in south Florida, every elementary school educator can expect two cocaine exposed children in their classes (Marks, 1990).

In Los Angeles, regular education costs \$3,500 a year. Special education costs \$9,000 a year. The city's pilot program for drug exposed kids costs \$15,000 a year and if no special steps are taken, the future costs in dropouts and increased crime, could be astronomical.'

Crack- cocaine hit the streets approximately five years ago, so now these children are reaching school age and no one knows the long-term consequences of prenatal exposure. Medical professionals, as well as others, do not know how much crack was taken, when it was ingested, and whether or not the pregnant women took crack in addition to other substances.

They will require a school system that understands and is ready to tackle this tragedy.

The New York City Board of Education has provided some money for this population, but it is not enough. Dr. Vincent Fontana of Mayor Dinkin's Task Force on Child Abuse is emphatic about starting interventions and treatment directly after birth (J. Young, DN Mag. 1990). By the time these children reach kindergarten, the delays are tremendous. There needs to be a working relationship between all professionals from the time these children are born. The Board of Education needs to use the additional funding to evaluate at-risk children, improve placement services, get additional social workers and psychologists. All sanctions of government and education need to get involved because this problem is too large for just one agency to solve.

Chapter 4

WHAT IS THE ROLE OF THE SCHOOL?

Experts suspect that our educational system already contains significant numbers of substance-exposed children. Because these children are of normal intelligence, however, the subtle deficits affecting their performance may remain undetected. Early research with substance-exposed preschoolers, the oldest group of children being followed by researchers, shows they are unable to function effectively in a traditional school setting. Thus, without assistance, substance-exposed children appear to be at great risk for school failure and for dropping out of school.

Yet the proper school setting can make a great difference in the lives of children affected by their parents' substance abuse. Structure, consistency, and concern are important components of this optimal learning environment, along with a good deal of individualized attention. Teachers who work with substance-exposed children must be familiar with related neurological impairments that affect learning and behavior. Rather than working in isolation, they must also be willing to work as part of a multidisciplinary team. In model early intervention programs, the first substance-exposed children under study are responding to such an approach by learning and growing.

WORKING WITH SUBSTANCE-ABUSED CHILDREN: ROLES OF THE SCHOOL STAFF

The Teacher should:

- be supportive of various intervention techniques that work with drug-exposed children (see "Teaching Strategies" in this chapter).
- be open-minded and willing to try new and different methods to meet the child's needs.
- be ready to coordinate with a variety of different resources and agencies to assist the child's cognitive, physical, emotional and behavioral development.
- through patience, love and understanding, provide the environment in which the child can progress comfortably and in which sometimes reluctant parents can be encouraged to participate in their child's development.
- coordinate with other school-level support staff to provide a team approach for each child.
- be provided with information related to identifying and assisting substance-exposed children.

The Counselor should:

- be able to identify signs and symptoms of drug-exposed children.
- be aware of assessment techniques and instruction for use with the child and the family.
- be able to provide specialized guidance and counseling in the school setting.
- be able to provide support and guidance for other staff members.
- be aware of community resources for information and referral.

The Principal should:

- be knowledgeable about signs and symptoms of drug-involved children.
- be sensitive to special needs of drug-involved children.
- be aware of special curriculum and instructional techniques necessary for use with these children.
- be knowledgeable about the affective as well as academic needs of drug-involved children.
- be aware of sources of training for staff in dealing with drug-involved children (see below).

The Child Care Center, Pre-kindergarten, and Kindergarten Director should:

- be able to recognize that drug-involved children will need special consideration in both practice and curriculum.
- arrange to provide for such special consideration as far as possible within the center's means
- pay special attention to staffing.
- use innovative ways of involving parents or guardians.
- be willing to refer drug-involved children for diagnostic screening if necessary.
- make arrangements for outside assistance if deemed important to the child's overall development.
- make it his or her responsibility to follow through on a child's referral to an outside source since continuity of care is critical.

Source: Kate Howze, M.S. and Wendell Howze, Ed.D., personal communication.

Some Sources of Training in Florida:

- Linda Delapenha, Supervisor, Primary Diagnostic Services, Department of Student Services, Hillsborough County Schools, 411 East Henderson Avenue, Tampa, FL 33602, (813) 272-4576.
- Shirley Davis, Director, Child Development Center, Operation PAR, 10901-C Roosevelt Blvd., Suite 1000, St. Petersburg, FL 33176, (813) 577-9728.
- Kate Howze, Community Relations Specialist, Juvenile Welfare Board of Pinellas County, 4140 Forty-Ninth St. N., St. Petersburg, FL 33709, (813) 521-1853.
- Wendell Howze, Assistant Principal, Northeast High School, 1717 54th Avenue, St. Petersburg, FL 33714, (813) 527-8441.

IDENTIFYING AT-RISK CHILDREN

The following list of behaviors was compiled by the staff of Los Angeles' Program for Children Prenatally Exposed to Drugs (PED). Substance-exposed children displaying these behaviors are at risk for school failure and a variety of related problems.

Perinatal Substance Abuse: Indicators for Early Intervention Services

Motor and Neurological Development

- tremulousness, tremors when reaching, increased startling
- poor quality of visual following
- poor visual attention to people and objects
- blanking out, staring spells, bizarre eye movement
- fine motor dexterity difficulty
- gross motor clumsiness

Affective and Behavioral Development

- lability of emotion, rapid shift from apathy to aggressiveness
- irritable, hyper-sensitive, explosive and impulsive behaviors
- depressed affect, decreased laughter
- difficulty in comforting self and being comforted
- marked difficulty with transitions and changes
- increased testing of limits
 - insists on doing tasks on own terms
 - persistent refusal to comply to simple commands
- inability to self-regulate or modulate own behavior (easily becomes over-excited, cannot calm down)

Social/Attachment Development

- decreased use of eye contact to initiate social interaction
- decreased use of gestures to initiate social interaction
- decreased/absent stranger and separation anxiety
- indiscriminate attachment to new people
- aggressiveness with peers
- decreased compliance to verbal direction
- decreased response to verbal praise
- decreased use of adults for solace, comfort and object attainment
- decreased use of adults to gain recognition for accomplishments

Problem Solving, Attention and Concentration Strategies

- poor on task attention
- increased distractability to extraneous sounds and movements
- inability to accommodate in problem solving situations
 - impulsive responses before "reflecting"
 - persistent use of ineffective problem solving strategies, or easily "gives up" without trying other strategies
 - decreased visual scanning of all components in problem solving situations
 - decreased use of trial and error strategies
 - delay in acquisition of sense task completion

Language Development

- fewer spontaneous vocalizations from early infancy
- delayed acquisition of words
- decreased use of acquired words/gestures to communicate wants and needs
- prolonged use of "in-class" errors in picture/object identification at preschool level
- prolonged infantile articulation at the preschool level
- difficulty in "word finding" at the preschool level

Play

- shows decreased spontaneous play with increased aimless wandering
- does not apply acquired adaptive skills in spontaneous stacking, marking and container play
- cannot organize own play, appears perplexed and confused, cannot select materials and focus adaptively
- shows delays, discontinuity and disorder in representational play
- easily overstimulated by too many things and people and by too much noise
- has difficulty with peer relationships in unsupervised play

Source: Program for Children Prenatally Exposed to Drugs (PED) Team,
Los Angeles Unified School District, Division of Special Education
PED Team: Carol Cole, Teacher

Victoria Ferrara, Teacher

Teresa Garcia, Psychologist

Deborah Johnson, Psychiatric Social Worker

Marci Blankett Schoenbaum, Teacher

Rachelle Tyler, M.D.

Valerie Wallace, Psychologist

Marie Poulson, Ph.D., University Affiliated Program, Children's Hospital

A MODEL PROGRAM

The following is excerpted from "Today's Challenge: Teaching Strategies for Working with Young Children Pre-natally Exposed to Drugs/Alcohol", a booklet developed in July 1989 by the staff of the Children Prenatally Exposed to Drugs (PED) Program of the Los Angeles Unified School District. The booklet was designed to provide guidelines for preschool programs wishing to meet the needs of substance-exposed children. The teaching strategies are organized in the areas of learning, play, social/emotional communication and motor development, and home/school partnership. In addition to specific teaching strategies, there are descriptions of normal development as well as behaviors that place prenatally-exposed children at risk.

Overview

Background

The Los Angeles Unified School District, Division of Special Education, has initiated a pilot project serving twenty families in two classrooms at Salvin Special Education School and one at 75th Street School. The pilot serves children ages 3-6 who have been prenatally exposed to drugs (PED). Using a transdisciplinary approach, a team consisting of teachers, psychologists, social workers, speech and language specialists, adapted physical education staff, a physician, and a nurse offer services to children and families.

Purpose

The pilot is designed to determine the educational strategies that will be necessary to serve this high risk population. Ongoing assessments and documentation help to identify the learning styles, behavioral characteristics and difficulties with bonding that are often found in these children. To promote understanding of these young children, special emphasis is placed on strengthening the home/school partnership, gathering and implementing data from related research, developing curriculum guidelines, providing parent/caretaker education and disseminating information to the community.

Entrance Criteria

- 1. Age: Three years, zero months to four years, zero months*
- 2. Cognitive Ability: Overall functioning within average range*
- 3. Medical: Prenatal exposure to drugs such as cocaine, PCP, heroin, etc. Children who have a medical condition such as a) seizures, b) deafness, c) blindness, d) severe mental retardation, e) severe physical disabilities, f) chromosomal abnormalities, that would qualify them for services on a special education site are not eligible for services in the PED program.*
- 4. Behavioral Characteristics: Children may exhibit any of the following: tremors, perceptual disorganization, blanking out, speech and language disorders, minimal development delays, disorganized play, difficulty with transitions, poor peer relationships and poor coping skills.*

Characteristics of Children Prenatally Exposed to Drugs/Alcohol

There is no "typical profile" of a drug-exposed child, and as such each child must be educated as an individual with particular strengths and vulnerabilities. Because the effects of prenatal alcohol or other drug use on children are varied, the continuum of impairment can range from minimal symptomology to severe impairment in all areas of the child's development. Characteristic behaviors include a heightened response to internal and external stimuli, irritability, agitation, tremors, hyperactivity, speech and language delays, poor task organization and processing difficulties, problems related to attachment and separation, poor social and play skills, and motor development delays.

While organic deficits caused by prenatal exposure to drugs cannot always be remediated, and while immunity against adverse child rearing conditions cannot always be created, high quality child/family intervention services can significantly improve a child's self esteem, self-control, and ability to solve problems in the real world.

Goals of the PED Program

- 1. To develop a preschool program that incorporates a family focus, systematic interdisciplinary assessments, individualized programming, consistent teaching, support staff, and program evaluation.*
- 2. To develop effective strategies and provide structured learning experiences to promote the cognitive, communicative, psychosocial, and motor development of children prenatally exposed to drugs including alcohol.*
- 3. To identify preschool children who are at-risk for behavioral and developmental learning problems due to prenatal alcohol or other drug exposure.*
- 4. To facilitate the successful transition of Prenatally Exposed To Drugs, PED, children to a regular education setting or to their least restrictive special education program placement.*
- 5. To promote a better understanding of young children who have been prenatally exposed to drugs including alcohol and who are at-risk for school failure.*

Philosophy of Program

The behaviors seen in the preschooler prenatally exposed to alcohol or other drugs are the result of a constellation of risk factors resulting from possible organic damage, early insecure attachment patterns, and ongoing environmental instability. The child is particularly vulnerable to many stresses that impact on daily living. The extremes observed in a child's behavior, be it passivity or hyperactivity, apathy or aggression, indiscriminate trust or extreme fear and suspicion, must be understood in the context of the child's experience.

Research has shown that the progress a child prenatally exposed to drugs is more favorable when the child is placed in a predictable, secure and stable environment; therefore, intervention programs for these children must include the development of protective environments with defined structure, expectations, and boundaries, as well as the provision of on-going nurturing and support. Early positive, responsive care is crucial for children's emotional and cognitive well-being. Establishing a strong attachment with each child through understanding and acceptance is a teacher's major priority. Only in the context of a good attachment will a child's true potential be realized.

BEST COPY AVAILABLE

Intervention strategies, to be effective, must attempt to counteract prenatal risk factors and stressful life events. To accomplish this, the teacher must build in protective factors within the classroom environment and provide facilitative ways for young children to cope appropriately with stress. Self-esteem, self-control, and problem solving mastery is best achieved when protective factors are coupled with a facilitative approach in the acquisition of better coping skills. These protective and facilitative factors are similar to those built into any good preschool program, but because children prenatally exposed to drug are more vulnerable, these program components are essential.

The following are protective factors to be built into a classroom for at-risk children:

A. Respect

Children at-risk need a setting composed of nurturing adults who are respectful of children's work and play space and who do not make unrealistic demands nor unpredictably appear and disappear.

B. Routines & Rituals

At-risk children need a setting which is predictable. Providing continuity and reliability through routines and rituals and scheduling activities to occur in a predictable order over time strengthen a child's self-control and sense of mastery over the environment.

In staffing programs for children at-risk, not all professionals (speech and language therapist, psychologist, social worker, etc.) come into the classroom weekly to interact with the children. These adults should develop a routine for reintroducing themselves and predicting for the children when they will appear again. Consistent personnel who help a child understand the visiting adult's schedule enhance the child's sense of security.

C. Observation & Assessments

The manner in which the child uses these skills during play, at transition time, and while engaged in self-help activities is equally important. Close observation of a child's behavior at these times allows for the understanding of how the child experiences stress, relieves tension, copes with obstacles, and reacts to change. It provides valuable information on how the child uses peers and adults to meet needs and solve problems.

D. Flexible Room Environment

Children at-risk need a setting in which classroom materials and equipment can be removed to reduce stimuli, or added, to enrich the activity.

E. Transition Time Plans

At-risk children need a setting in which transition time is seen as an activity in and of itself and as such has a beginning, middle, and end. Special preparation is given to transition time, recognizing that it is one of the best times of the day to teach the child how to prepare for and cope with change and ambivalence.

F. Adult:Child Ratio

Children at-risk need a setting in which the adult:child ratio is low enough to promote attachment, predictability, nurturing, and on-going assistance in learning appropriate coping styles.

The following are facilitative factors to be built into a classroom for children prenatally exposed to drugs:

A. Attachment

Children at-risk need a teacher who accepts the child with a history of both positive and negative experiences. It is assumed that for a high-risk child, there may be a history of poor attachments and lack of trust. The degree to which a child comes to trust the world depends, to a great extent, upon the quality of care received. When care is inconsistent, inadequate, or rejecting, it fosters mistrust, fear, suspicion, apathy, or anger towards the world and people in particular. These feelings will carry through to later stages of development.

B. Feelings

Children at-risk need a teacher who accepts that children have negative and positive feelings. Feelings are real, important, and legitimate. Children behave and misbehave for a reason, even if it cannot be figured out. In responding to a child's misbehavior, the first priority should be to acknowledge what the child seems to want, before dealing with the misbehavior. Doing so allows the child to recognize that his/her feelings are real and valid. Being understood facilitates self-esteem and promotes a willingness to function within prescribed limits.

Different children respond to stress (internal or external) in different ways. Individual children show different responses to the same stressful events on different days. Teachers need to develop a sensitivity to the particular meaning different stressors have for the individual child and not have a predetermined set of expectations for or responses to child behavior.

C. Mutual Discussion

At-risk children need a teacher who acknowledges that children's behavior, feelings and experiences are open to mutual discussion. Talking about behavior and feelings, (done with empathy rather than judgment) validates the child's experiences and sets up an accepting atmosphere. Permission to have these feelings leads to the increased ability to distinguish between wishes and fantasies on the one hand, and reality on the other. Verbal expression allows the integrating process that leads to the child's increased ability to modulate behavior, gain self-control, and express feelings.

D. Classroom Rules

Children at-risk need a setting in which the number of explicitly stated rules are limited. By limiting classroom rules, children are encouraged to explore and actively engage in their social and physical environment. While it is possible to teach specific objectives by relying on rules to control the child, it may be at the expense of the child's intrinsic motivation, problem solving capacity, and self-mastery.

E. Role Model

Children at-risk need a teacher who understands that by establishing an individual, trusting relationship, the teacher becomes an important person, and behavior the teacher models is more likely to be imitated.

F. Peer Sensitivity

At-risk children need a teacher who realizes that children become sensitive and aware of the needs and feelings of others only by repeatedly having their own needs met.

G. Decision-Making

Children at-risk need a teacher who recognizes that it is important that they be allowed to make decisions for themselves. Freedom to choose and to assume the responsibility for those choices gradually expands the in view of the child's physical, social, emotional, and intellectual growth and promotes self-esteem, problem solving mastery, and moral values.

H. Home

The home is recognized as an essential part of the curriculum. Facilitating parental/caregiver goals helps to establish a close working relationship between home and school. Intervention strategies that strengthen the positive interaction between child and family increase parental confidence and competency.

I. Program

Program intervention is best achieved when all professionals concerned with the child and family are coordinated. To accomplish this successfully, time must be allotted for teachers to meet and plan with assistants and for support services of social workers, psychologists, speech and language, and adaptive physical education to come together in a transdisciplinary model.

Teaching Strategies

A. Learning

Learning occurs in a developmental framework. Development is an internal process in which the child is consistently organizing and reorganizing experiences within a continuum of stages. Movement through the stages is not an automatic passive activity. From birth, a child who has not been exposed to drugs/alcohol has the potential to attend and respond to selected stimuli and take the initiative to explore and control the environment.

Competency to perceive and explore the environment can be damaged in the child prenatally exposed to drugs/alcohol. Concrete experiences, decision-making and problem solving within a nurturing environment as well as a positive interactive communication help to build the foundation for development. This foundation promotes self-esteem, competence and motivation for new learning.

NORMAL LEARNING DEVELOPMENT

The child:

- *learns to focus on tasks in play situations.*
- *uses numerous problem-solving strategies.*
- *shows sustained attention in individual and small group activity.*
- *develops a sense of task completion.*
- *steadily progresses in the acquisition of skills.*
- *learns to delay immediate needs and to conform to the social expectations of the classroom.*
- *is able to end a preferred activity and start a teacher-directed activity.*
- *demonstrates sporadic/intermittent mastery of skills in new learning situations.*
- *acquires pre-academic concepts through incidental learning.*

LEARNING BEHAVIOR OF AT-RISK CHILDREN

The child:

- *may easily be distracted by sounds, people, and movement.*
- *may have poor visual scanning.*
- *may show decreased trial and error.*
- *may show decreased problem-solving strategies.*
- *may have decreased attention and concentration.*
- *may show perseverative behavior in problem solving.*
- *may show decreased task completion.*
- *may need longer time to complete task.*
- *may give up easily when confronted by problem-solving situations.*
- *may be easily frustrated and become irritable in problem-solving situations.*
- *may be unable to do task previously mastered.*
- *may be unable to take turns.*
- *may not remain seated in circle or at the table with the other children.*
- *may withdraw from a lack of social and environmental stimulation and may learn to become non-responsive.*
- *may not have regular play/rest cycles or patterns.*
- *may become upset with changes in routine.*
- *may have difficulty with changes/transitions.*
- *may be unable to end or let go of preferred object or activity.*
- *may demonstrate sporadic/intermittent mastery of skills over prolonged period of time.*
- *may not learn incidentally.*

TEACHING STRATEGIES FOR OPTIMAL LEARNING

Teaching staff:

- *provides support and emotional reassurance.*
- *reduces classroom interruptions as much as possible.*
- *limits number of objects in room.*
- *establishes classroom routines with minimum number of transitions.*
- *models alternative strategies.*
- *directs child to watch another child who is using a successful strategy.*
- *considers developmental level of child.*
- *recognizes preschoolers may need to sit in adult's lap.*
- *recognizes preschoolers may need to sit next to an adult.*
- *uses physical, concrete, and verbal cues to direct or redirect child in task or activity.*
- *recognizes and consistently praises child's attempts and accomplishments.*
- *asks child to verbalize steps of a task.*
- *provides verbal cues (talks the child through task) if child is unable to verbally give steps of task.*
- *provides the child with an opportunity to take turns with peers and adults.*
- *models taking turns.*
- *provides attention and time to children who are behaving appropriately.*
- *protects child from the over-stimulation of intrusive persons or noisy environments and from the under-stimulation of a bland social and environmental experience.*
- *provides the child a schedule of play and rest activities to help develop regular patterns.*
- *alerts the children routinely 1-2 minutes ahead of time that the activity will soon be over.*
- *talks about the next activity before entering into the activity.*
- *allows adequate time for the transition activity.*
- *guides the child through the transition and into the next activity.*

B. Play

Play is the area where a child integrates learning, communication and social/emotional and motor skills. Through play, a child can learn to understand him/herself and the relation to others and the world around him/her. As a child grows and matures his/her play involves increased communication skills, attention, concentration, and concept development. Strategies for play are important because a child prenatally exposed to alcohol and other drugs is at-risk for poor play skills.

NORMAL DEVELOPMENT PLAY

The child:

- *learns to organize his/her own play.*
- *can independently select materials and focus on them in an appropriate manner.*
- *progresses from parallel to interactive play.*
- *joins in play with other children.*
- *initiates interactive play.*
- *takes part in and initiates dramatic play.*

PLAY BEHAVIOR OF AT-RISK CHILDREN

The child:

- *may show decreased spontaneous play with increased aimless wandering.*
- *may not organize own play, appear perplexed and confused and cannot select materials and focus adaptively.*
- *may be easily over-stimulated by too many things and people and by too much noise, movement and excitement.*
- *may show delay, discontinuity, and disorder in representation play.*
- *may have difficulty joining others in play.*
- *may not initiate appropriate interactive play.*
- *may not initiate dramatic play.*

TEACHING STRATEGIES FOR OPTIMAL PLAY DEVELOPMENT

Teaching staff:

- *gives child toys and/or areas in the classroom that are child's alone, and do not have to be shared.*
- *recognizes that the child may not have had consistent play objects in his/her environment.*
- *finds out what is available for the child in child's home.*
- *decreases/regulates amount of toys for child.*
- *responds to and follows the child's lead in play.*
- *models toy choices for child with correct verbal cues.*
- *verbally and physically models play with toys.*
- *provides opportunities for the child to play interactively in a safe environment with the adult available for assistance and reassurance.*
- *provides child with opportunities to take turns with peers and adults.*
- *provides time to model interactive play.*
- *provides child with support and encouragement during play.*
- *initiates and models dramatic play with child.*
- *responds to child when child initiates dramatic play by verbal responses or by playing with the child.*

C. Social/Emotional

When interactions between the drug exposed infant and caregivers result in lack of attachment rejecting or inconsistent care, this child is at greater risk for developing mistrust, suspicion and fear. These attitudes may carry through to later stages of development and manifest themselves behaviorally. Exaggerated behavior patterns are often the way a child copes with a situation that is overwhelming. Each child must be made to feel emotionally safe to attempt new learning. It is important to establish a responsive, nurturing environment conducive to active learning in which the child may build a positive self-concept.

NORMAL SOCIAL/EMOTIONAL DEVELOPMENT

The child:

- develops and maintains healthy attachments.
- separates from parent when trust has been established.
- learns to look for and respond to adult approval.
- learns to respond to gestural/verbal praise and setting of limits by teacher.
- forms attachment to teacher.
- learns to socially signal desires and needs.
- learns to interpret and respond to social cues of adults.
- learns to read and respond to social cues of peers.
- shows broad range of emotions, including pleasure, anger, fear, curiosity, and assertiveness.
- shows a balance in emotions.
- learns to regulate own inner-state.
- responds to emotions of others.
- learns to develop an independent sense of self and responsible behavior resulting in self-esteem.
- develops a strong self-interest.

SOCIAL/EMOTIONAL BEHAVIOR OF AT-RISK CHILDREN

The child:

- may not use adults for comfort, play, approval, or object attainment.
- may go from one to another showing no preference for a particular adult.
- may not look to adult for recognition of a job well done.
- may not respond in any way to verbal praise from adult.
- may ignore verbal/gestural limit setting.
- may show decreased compliance with routine simple commands.
- may show indiscriminate attachment to all adults.
- may not signal desires by giving eye contact, gesturing, or vocalizing.
- may not read teacher's cue/look.
- may show a restricted range of emotion.
 - overreacts to "no" by total withdrawal.
 - rarely smiles, laughs, or show joy.
 - lethargy, listlessness, lack of affect.
 - clingy behavior with adult.
- may not express fear, grief, worry.
- may withdraw, seem to daydream, or not be there.
- may have poor inner controls (giggles turn into screams).
- may remain clingy and dependent on teacher for decisions and daily living activities for extended periods of time.
 - may overreact to separations from primary caregiver.
 - may show some lack of self-awareness as an individual.
- may not show concern for hurt peers.

TEACHING STRATEGIES FOR OPTIMAL SOCIAL/EMOTIONAL DEVELOPMENT

Teaching staff:

- *provides opportunities for contact, mutual touch, and smiling throughout the day.*
- *responds to specific needs of child with predictability and regularity.*
- *addresses child by name, elicits eye contact, and/or touches child before giving verbal command.*
- *talks child through to consequence of child's action.*
- *provides the child with explicitly consistent limits of behavior.*
- *takes every opportunity to develop teacher child relations.*
- *uses close proximity and gestures.*
- *responds to muted signals and gives child a verbal explanation of child's behavior.*
- *moves close to the child, looks at the child, and helps the child to read teacher's cues by explaining to the child what the teacher's look, body language, or gesture means.*
- *labels expression of emotions so child learns to identify those emotions.*
- *uses books, pictures, doll play, and conversation to explore and help child express a range of feelings.*
- *allows, identifies, and reacts to child's expression of emotions:*
 - *pleasure*
 - *protest*
 - *excitement*
 - *anger*
 - *self-assertion*
 - *curiosity*
 - *dependency*
 - *love*
 - *fear*
- *models full range of emotions for child.*
- *communicates with caregiver and finds out if there has been an upset in the home or any change of routine in the home, any family emergency or if the child's sleeping pattern has changed.*
- *assists child in gaining control by:*
 - *getting eye contact.*
 - *sitting next to the child.*
 - *verbal reassurance.*
 - *physical comfort, (i.e., teacher rubs child's back).*
- *uses stories, puppets, and role play to develop empathy for others.*
- *provides daily opportunity for the child to practice independent feeding, dressing, bathing, toileting, and play skills with tolerance for messiness and dawdling.*
- *provides child with a daily opportunity to make small decisions and limited choices in play and/or self-help activities.*
- *has activities centered around the child as an individual.*
- *provides spaces and objects in the classroom that are for each child (cubbies with names, personal toys from home, and individual picture books).*

D. Communication

The child's capacity to communicate evolves from early mother-child interaction. The development of a child's language depends on the child's ability to receive, understand, integrate, and express meaningful experiences. The child learns to use gestures/words to express feelings, communicate wants, and describe experiences. A child learns language best through social interaction with significant individuals and through active exploration of his/her environment.

NORMAL COMMUNICATION DEVELOPMENT

The child:

- *is able to follow directions appropriate for his developmental level (simple commands, multiple commands).*
- *learns to communicate simple wants and needs, name objects, express feelings at appropriate developmental levels, and describe experiences and events.*
- *is able to use pragmatic language.*
- *learns to initiate appropriate interactions with peers.*

COMMUNICATION BEHAVIORS OF AT-RISK CHILDREN

The child:

- *may have delayed receptive and expressive language.*
- *may be unable to follow directions that are appropriate for the child's developmental level.*
- *may have prolonged infantile articulation at the preschool level.*
- *may not use attained language to communicate feelings, wants, and needs.*
- *may be unable to verbalize his/her needs, wants and fears, and expresses them through behavior such as banging, stomping, shouting.*
- *may show listlessness, passivity, and/or lack of social awareness.*
- *may observe rather than verbally engage with peers in play.*
- *may inappropriately initiate interaction with peers by:*
 - *hitting*
 - *pushing*
 - *biting*
 - *swearing*
 - *negative verbal remarks.*

TEACHING STRATEGIES FOR OPTIMAL COMMUNICATION DEVELOPMENT

Teaching staff:

- *creates a stable environment where child feels safe to express feelings, wants, and needs.*
- *uses "hands-on" activities to reinforce the child's language.*
- *uses eye contact, gives simple one step directions, and gradually increases the number of steps in a direction.*
- *maps language in the context of the activity.*
- *provides names of people, pets, food items, body parts, objects, feelings, and events in the process of conversation.*
- *immediately responds to beginning attempts at verbal communication.*
- *investigates child's behavior by asking child questions to discover what child needs, wants, or fears.*
- *acknowledges the needs, wants or fears of the child.*
- *provides strategies to enable the child to appropriately express needs, wants, or fears.*
- *acknowledges attempts by child to cooperate and interact with other children.*
- *recognizes negative behavior may be a signal of child's unmet needs.*
- *reflects child's feelings.*

- *verbally directs child's behavior.*
- *praises child's attempts toward adaptive behavior.*
- *ignores inconsequential verbal behavior.*
- *verbalizes expected behaviors.*
- *redirects behavior.*
- *removes child and helps child calm self.*
- *provides child verbal language to use with other children.*
- *intercedes with extra support for child who has used best developmental skills to resolve conflict without success.*
- *sets consistent limits on inappropriate behavior, but allows for expression of feelings.*
- *provides time to talk with child about emotions.*

E. Motor

Motor and spatial development stems from the interplay of a number of factors beginning prenatally and continuing through early childhood. Any major interferences along this continuum can result in motor/spatial impairment. As a result of prenatal exposure to alcohol and other drugs, the child may exhibit varying degrees of fine, gross motor, and spatial relationship delays.

NORMAL MOTOR/SPATIAL DEVELOPMENT

The child:

- *has awareness of child's body placement in relationship to his/her environment.*
- *has age appropriate gross motor skills.*
- *has awareness of space relationships among objects in relationship to self.*
- *has awareness of space relationship among objects in relationship to each other.*
- *is able to manipulate objects, age appropriately.*

MOTOR/SPATIAL BEHAVIOR OF AT-RISK CHILDREN

The child:

- *may trip or stumble without apparent cause.*
- *may have difficulty with gross motor skills (e.g., swinging, climbing, throwing, catching, jumping, running, and balancing).*
- *may walk into stationary or moving objects.*
- *may move too close or too far away from another object.*
- *may show splaying of fingers, immature grasping skills.*
- *may have difficulty manipulating objects (stacking, stringing, cutting, and drawing).*
- *may exhibit tremors when stacking, stringing, or drawing.*

TEACHING STRATEGIES

Teaching staff:

- *verbally reminds child of obstacles.*
- *guides child through motor activities that emphasize the skills of rhythm, balance, and coordination.*
- *models and guides child in learning to control child's body through songs, games, and play.*
- *provides child with opportunities to experience spatial relationship through motor mazes, outdoor play, and indoor play.*
- *provides a variety of tactile and small motor activities (water and sand play, pegboards, puzzles, blocks, legos, etc.).*
- *observes child and notes tremor occurrences and duration and how child compensates for tremors.*

F. Home-School Partnership

The home is recognized as an essential part of the curriculum. Research has indicated that early intervention programs are essential in producing long-term positive results only when parents/caregivers are part of the program design. Interactions between teachers and parents/caregivers must be professional, sensitive, and flexible. This relationship must be based on the expression of mutual concern and goals. Parents of children at-risk may themselves have past and/or present experiences which can compromise their ability to effectively parent their children. Factors, which may include poverty, depression, a history of child abuse/neglect, family instability and violence, history of psychiatric problems, drug abuse, etc., are taken into consideration when staff is addressing the child's needs with the parent.

Children who reside in foster homes or are placed with extended family members are particularly vulnerable to the consequences of separation, loss, and poor attachments. These children require ongoing support and coordinated case management plans with the goal of maximizing the child's success within the home and in the school. The emphasis on strengthening the positive interaction between caregiver and child increases the caregiver's awareness and understanding of the child's individual needs and assists in promoting feelings of confidence and competency within the caregiver. This empowerment of the caregiver will benefit the child far beyond his/her formal school program.

Having the knowledge of school/community resources and a genuine interest in the parent's well-being are essential to bridging the home-school partnership.

HEALTHY HOME ENVIRONMENT

The child:

- will have a mother who receives proper prenatal care.
- is provided consistent, responsive primary caregiver from birth.
- is provided predictable, safe, stable environment.
- has regular eating and sleeping patterns.
- will have a mother/primary caregiver who sees herself as child's first teacher.
- is provided with established family rituals around daily living activities and special events.
- is provided appropriate developmental activities.
- is encouraged to express feelings.
- is encouraged to be self-sufficient and independent.

AT-RISK ENVIRONMENT

The child:

- with prenatal exposure to drugs/alcohol may:
 - be premature
 - be small for gestational age
 - go through withdrawalsuffer damage to gastrointestinal, endocrine, respiratory, genito-urinary, cardiovascular and/or central nervous systems.
- may have multiple home placements.
- may have multiple caregivers.
- may live with other young children who are at-risk.
- may be abused and neglected.
- may receive inconsistent and intermittent nurturing.
- may have caregiver who is emotionally unavailable.
- may have caregiver who is overwhelmed or untrained in dealing with the child's emotional needs.
- may be exposed to chaotic, unpredictable, and unstable environments.

TEACHING STRATEGIES OPTIMAL HOME-SCHOOL PARTNERSHIP

Teaching staff:

- identifies family constellation and primary caregiver.
- develops relationship with caregiver and lines of communication.
- schedules on-going visits to:
 - develop a child's history (number of placements, medical history, family history, other agency involvement).
 - explore what they are doing about child's behavior.
 - discuss observations of child's behavior and progress.
 - observe and discuss caregiver/child relationship.
 - identify parental concerns and assess family needs.
 - develop individual family service plan.
 - facilitate referral to other agencies as services are needed.
 - encourage participation in parent education classes.
- discusses and models the importance of predictability and organization:
 - by developing a transition plan with caregiver for entering school (books, toys, expected parent attendance).
 - by establishing regular patterns of communications with home (phone calls, classroom newsletter, informal notes, notebook back and forth).
 - by anticipating, discussing and integrating events at home and school (daily routine, special events).
 - by discussing implications of prenatal exposure to drugs/alcohol (short-term and long-term effects).
 - by promoting an understanding of psychosocial risk factors (abuse, neglect, multiple placements).

A Teacher's Personal Account

Young Children Prenatally Exposed to Drugs in the School Setting
by Carol Cole, M.A., Teacher, Los Angeles Unified School District

Children prenatally exposed to drugs entering the preschool setting bring with them a constellation of risk factors. The behaviors seen in the classroom may be the result of possible organic damage, early insecure attachment patterns, and often ongoing environmental instability. These children are particularly sensitive to the many stressors that impact on their daily lives. The extremes observed in a child's behavior, be it passivity, hyperactivity, apathy or aggression must be understood in the context of the child's experience. The average child in our pilot program had approximately three placements by three years of age.

When we began three years ago, we were aware that the literature described babies prenatally exposed to drugs as having a poor arousal response, being difficult to soothe, showing poor organization to environmental sounds, and being poor eaters and sleepers. We read that drug using mothers had a history of poor prenatal care, dysfunctional relationships, chaotic lifestyles and poor parenting skills.

What we didn't know was how the developmental line of vulnerabilities or impairments would manifest themselves in the three and four year old child in the school setting. We thought we could pinpoint different behavior and attribute it to a particular drug. We also thought we might be able to tease out the effects of the drugs from those environmentally induced difficulties. We could not. The children

are the product of poly drug abuse in utero, the abuse occurring at different times during the pregnancy, for different durations and at different intensity while in the womb. Perhaps, more importantly, we could not clearly distinguish the difference between the impact of the drug and the impact of the environment.

Three year old C. was reported to have been exposed to cocaine, pcp, and alcohol in utero. In school, he knew his colors, and was beginning to read. Yet, often, his response to simple teacher demands to participate in chassroom activities and routines would result in temper tantrums, foul language, drooling, spitting, and undressing. C. lived in a group home for six children, all under the age of five. There was a rotating staff of nine caregivers. This was the 8th placement that C. had experienced in his short three years. Was the inappropriate behavior we saw in the classroom the result of the drugs or because of the multiple placements . . . or was it both?

We have learned that these children are more alike than different from their typical peers and that while we know drug exposure can cause a continuum of impairments, from severe handicapping conditions to risk factors, there is no typical profile. Likewise, there is no typical generalization that can be made about the families and caretakers of these children. Both must be served with sensitivity to their unique strengths as well as needs. Children prenatally exposed to drugs are not atypical or dissimilar from other vulnerable children. However, the combination of both organic and environmental insults leaves these children in need of specialized curriculum and services. These children's cognitive competence is often not enough to protect them from school failure. Therefore, specialized, but not necessarily separate from other high risk or typical children, early intervention is necessary for these children.

The intervention strategies, to be effective, must attempt to counteract prenatal risk factors and stressful life events. School curriculum and social services provided these children must incorporate the basic principles of building attachment and trust.

The beginning of moral development for children rests in part with the degree to which they learn to trust the world . . . and of course the people in that world. Attachment is the word we use, the shorthand, to convey that a child has that base of trust. Attachment is the initial building block for all learning: cognitive, emotional, behavioral . . . It is fundamental for extending simple cause and effect knowledge into the more complex realm of socially appropriate behavior and abstract thinking. Research indicates that one person, advocating for a child can have tremendous influence in the outcome of that child.

Our experience is that a majority of children coming into our program have a history of poor attachment and lack of trust. Therefore, it is a major priority for teachers to establish a strong relationship with each child and family. A major focus is not just school readiness skills, but rather on relationships and attachment. Teachers modeling concerned nurturing, predictable interaction with respect for feelings can teach a lesson far more important that colors, numbers, letters, size and shape. That is:

- adults can be trusted
- needs will be met
- children are valued

Hillsborough County's Response: The Drug-Exposed Children's Committee

The Drug-Exposed Children's Committee (DECC) in Hillsborough County, Florida, investigated the needs of young children exposed to alcohol and other drugs to see if modifications were needed within regular education/pre-school programs. An informal assessment was conducted in May 1989, to see if there were children in kindergarten Head Start and other pre-kindergarten programs who were thought to be drug-exposed, and to see the kinds of problems they were experiencing. Schools with "at risk" populations did have drug-exposed students and hypotheses were generated about possible problems.

A five year longitudinal study of children from three to six years of age is currently being implemented. If we are successful in validating our pre-K and kindergarten checklist for symptomatic behaviors, children will be selected for the study based on teacher observation. The Committee has developed a checklist of behavioral characteristics associated with prenatal exposure, compiled from data from Los Angeles City Schools, research, and our own observations. Drug exposure will be validated by a parent interview. Initial funding for the study is provided by the University of South Florida Institute for At-Risk Infants, Children, and Their Families. The number of children identified for study during the 1989-90 school year will be determined by the level of funding received. Descriptive data will then be collected for all children in the study, such as screening test scores, promotion/retention data, teacher observations, etc., over a five year period of time.

This Committee is actively providing inservice to teachers and other school personnel to allay their fears of this problem, and to present current research and information. A staff development component has been written to address Teaching Strategies for Children Pre-natally Exposed to Drugs. The syllabus is being developed with September 1990, as a target date for offering the course through the Teacher Education Center for re-certification credit.

Source: Linda Delapenha, Member
Drug Exposed Children's Committee
(DECC) of Hillsborough County
Supervisor, Primary Diagnostic Services
Hillsborough County Schools, Florida

Operation PAR's Child Development and Family Guidance Center

Since 1971, Operation PAR has addressed the problems of drug and alcohol abuse in Pinellas County, Florida. Operation PAR's Child Development and Family Guidance Center provides innovative, comprehensive, community-coordinated services designed to serve infants and children affected by parental chemical dependency. Working with the local county health unit, pediatricians, child protection teams, state protective services, juvenile court services, and chemical dependency treatment teams, the program strives to prevent multigenerational chemical dependence.

One component of the program is a special center serving children of two months to five years whose parents are serious drug abusers, especially parents abusing cocaine. The children participate in a wide variety of learning experiences designed to assess and develop their physical, emotional, social, creative, cognitive, language and self-help skills.

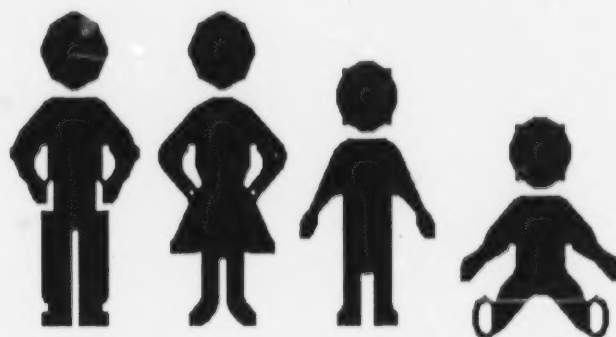
Infants and pre-school children are assisted to:

- feel secure in a healthy and safe environment.
- develop or enhance primary and trust relationships.
- nurture and grow in a positive social environment where satisfying interpersonal relationships can be developed through interaction with peers and adults.
- develop effective verbal and non-verbal communication skills.
- improve self-concept and self-esteem.
- improve perceptual motor activity.
- express feelings and perceptions, and enhance creativity through music, art, drama and dance therapy.

Each child is given a comprehensive screening to determine his or her developmental competencies. Children who have indicators of serious development deficits are further tested in order to determine appropriate educational and intervention plans. All children have personalized learning objectives developed with their parent(s) and ongoing evaluation to determine progress toward meeting individual goals. All parents participate in seminars and educational classes designed to enhance their potential skills and competencies.

For more information, call Shirley Davis, Director, Child Development and Family Guidance Center, (813) 896-2672.

***STRATEGIES FOR TEACHING
YOUNG CHILDREN AT RISK AND/OR
PRENATALLY EXPOSED TO DRUGS***



Prepared by:

Drug Exposed Children's Committee

**Hillsborough County Public Schools
Tampa, Florida**

DECC COMMITTEE MEMBERS

Linda Delapenha, Chairman	Supervisor of Primary Diagnostic Services
Lizette Alexander	Supervisor of School Psychological Services
Joan Altshuler	Pre-Kindergarten Diagnostician
Ellie Baehr	Kindergarten Teacher
Regina Birrenkott	Director of Mendez Foundation
Louis Bowers, Ph.D.	Professor of Physical Education, University of South Florida
Pat Crosby	School Social Worker
Donna Kimes	Supervisor of Pre-K Handicapped Programs
Paula Like	Supervisor of Early Childhood Programs
Mary O'Neill	Coordinator of Head Start Social Services
Sonia Picallo	Supervisor of Early Childhood Infant and Toddler Programs
Madeline Rose, Ph.D.	Kindergarten Teacher
Jean McCarthy, M.D., Ph.D. Medical Advisor	Neonatologist, All Children's Hospital, St. Petersburg, Florida, and Clinical Associate Professor of Pediatrics, University of South Florida.

RESOURCES

Materials, Training and Consultants

Early Recognition Intervention Network (ERIN)
376 Bridge Street
Dedham, MA 02026

Teaching Participation - sound filmstrip
Make It With Participation
Teaching Participation

High Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198

Program Implimentation Profile -
physical environment section
"Young Children in Action" by Mary Hohmann,
Bernard Banet & David P. Weikart

Child Abuse Conference in Tampa (January 25, 1990) presentations by Dr.
Jean McCarthy and Betsy Vaught.

Operation PAR, Child Development and Family Guidance Center.
(December 1989) Visits made to center.

National Association for Perinatal Addiction Research and Education
(NAPARE). (September 16, 1989, National Conference) Drugs, Alcohol,
Pregnancy and Parenting; An Intervention Model. Presented by Los Angeles
City Schools PED project.

Operation PAR. (February 6 - 8, 1990, Annual Conference). Substance Abuse
and Pregnancy: "Babies Deserve Better."

Juvenile Welfare Board of Pinellas County. (April 6, 1990, Conference).
Working With the Child Prenatally Exposed to Drugs. Presented by Shirley
Davis of Operation PAR, and Carol Cole from Los Angeles PED Project.

Maternal Child Health Coalition Conference. (June 1, 1990). "The Drug
Exposed Mother and Child; Putting the Pieces Together. Issues for Prevention
and Intervention in Hillsborough County."

McCarthy, Jean, M.D., Neonatologist at All Children's Hospital in St.
Petersburg, FL.

Central Florida Community College (June 26, 1990) "Cocaines Innocent Casualties"
Ocala, Florida

Video Tapes

March of Dimes "Cocaine's Children"

"A Lifetime of Discovery" from I'm Special Series - USF College of Education
County made tapes.

**Strategies for Teaching Children
Prenatally Exposed to Drugs**

Session 1: INTRODUCTION TO CHILDREN PRENATALLY EXPOSED TO DRUGS

1. **Purpose:** To introduce the course and give participants background information pertinent to the topic.
2. **Concepts:**

Statistics can only give us estimates of the number of babies prenatally exposed to drugs.

The numbers of babies born prenatally exposed to drugs is increasing each year.

The effects of prenatal exposure to drugs vary for each child from no effects to serious problems.

Early intervention for babies can significantly reduce the adverse effects of drugs.

The developing fetus is affected differently than the mother by the ingestion of cocaine.

There is a constellation of early behaviors in the drug exposed infant that can place them at developmental risk.

Toddlers may respond differently to adults when "at risk."

"At risk" behaviors have been identified for young children in the LA-PED program who are ages 4 - 7.

Interventions for infants and toddlers have already been identified and can be found in the literature.

Longitudinal research is being conducted by Dan Griffith, Ph.D., associated with NAPARE in Chicago, Illinois.
3. **Activities:** Lecture

View video tape

Distribute course materials
4. **Resources:** Video tape: March of Dimes "Cocaine's Children"

Overheads/slides

Course materials in a handbook form
5. **Assignment:** Complete an environmental checklist (adapted from High Scope) for room arrangement to bring back to next session

Session 2:

HOW THE CLASSROOM SHOULD LOOK

1. Purpose: The "at risk" child requires more structure and clarification within the environment than do other children, but all children are more successful, particularly at the beginning of the year, if their environment is constant and clear.
2. Concepts: Children at risk need a setting in which classroom materials and equipment can be removed, to reduce stimuli, or added to enrich the activity.

The "at risk" child needs assistance in self organization by interacting within an orderly, child appropriate environment.

When creating an appropriate room environment the following must be considered:
 1. Centers
 2. Space
 3. Boundaries
 4. Material storage
 5. Labeling of materials, areas.
 6. Furniture arrangement
3. Activities: Discuss results of environmental check list (last week's homework)

View filmstrip

View slides of positive examples.

Teachers work in small groups to arrange ideal room.
4. Resources: Sound-filmstrip "Teaching Through Participation" from ERIN part 2

Slides of good classroom examples of control of visual stimulation

Furniture cut-outs

Materials on physical environment
5. Assignment: Select and color the pictures from the ERIN program to use in making schedules; complete a checklist on scheduling.

Session 3:

SCHEDULING AND ROUTINES IN THE CLASSROOM

1. Purpose: Through scheduling and routines, a child can develop self-control, organizational patterns and experience success in the classroom.
2. Concepts: Children at risk need a classroom setting that is predictable. A child's ability to predict and anticipate the order of daily activities reduces anxiety.

A representational chart of activities that the children can see and follow helps them understand the meaning of time as it relates to the order of the day. (linear time)

Self organization skills include:
 Attention
 Getting the point
 Organizing
 Monitoring
3. Activities: Review checklist on scheduling (last week's homework).

"Make and take" a daily schedule

Preview self-organization model of ERIN program.
4. Resources: Materials to make a daily schedule: plastic pockets, folders, colored pictures, etc.

Scheduling materials
5. Assignment: Make observation of "self organization" taken from the ERIN program for 5 students.

Session 4:

THE TEACHER AS THE FACILITATOR WHEN WORKING
WITH AN "AT RISK" POPULATION

1. Purpose: Explore the role of the teacher as a helper of children to use their environment in an organized manner, and a facilitator of parent involvement.
2. Concepts: Young children require instruction in the use of the classroom environment. Visual cues can help young children learn the rules.

Transition times should be seen as an activity in and of itself with a beginning, middle and end.

Young children need to have a small number of choices of activities that they may always do when they complete seatwork or a center.

Discipline is an important teaching tool, not punishment. Consistency of discipline is essential with "at risk" children.
3. Activities: Review transition checklists (homework from last week)

Small group discussion of transition strategies.

View film strip/slides

Make procedure cards or block books.
4. Resources: Transition checklists

Observation checklists

Copies of materials necessary to make teaching aids.
5. Assignment: Administer and bring to next class: 2 child observation checklists

Session 5:

SOCIAL-EMOTIONAL DEVELOPMENT
FOR THE YOUNG CHILD

1. Purpose: Using a child development model, teachers will learn about age appropriate behavior, "at risk" behavior, and alternative strategies to use in the classroom.
2. Concepts: When lack of attachment occurs in the drug exposed infant, the child is at greater risk for developing mistrust, suspicion, and fear. These attitudes may carry through to later stages of development and manifest themselves behaviorally.

Exaggerated behavior patterns are often the way a child copes with stress.

It is important to establish a responsive, nurturing environment conducive to active learning so the child can build a positive self concept.

Children with prenatal drug exposure having difficulty expressing their feelings and need assistance in learning to do so.
3. Activities: Listen to audio tape
Small group problem solving activity
4. Resources: "Teaching Strategies for Working With Young Children Prenatally Exposed to Drugs/Alcohol" Los Angeles Unified School District

"Penny Tapes" by Elaine Violana

Social Skills materials.
5. Assignment: Using a checklist to identify specific behaviors, write interventions for one child and bring to next class.

Session 6:

MOTOR AND LANGUAGE SKILLS FOR THE YOUNG CHILD

1. Purpose: Using a child developmental model, teachers will learn about age appropriate behavior, "at risk" behavior, and alternative strategies to use in the classroom.

2. Concepts: As a result of prenatal exposure to drugs/alcohol, a child may exhibit varying degrees of fine, gross motor, spatial relationship and speech/language delays.

The regular classroom teacher can provide appropriate experiences and opportunities for children to develop language and motor skills

Children with neurological immaturities benefit from learning tasks that require motor movement, particularly when using language.

The understanding of growth patterns and capabilities of children at different ages helps teachers establish developmentally appropriate language and movement experiences.

Language must be modeled and used in order for children to develop and enhance their own language.

3. Activities: Make motor concept word games

Make materials to use with classroom records

Post test

Complete forms for staff development

4. Resources: Classroom records

Video: "A Lifetime of Discovery" from I'm Special Series.

Normal motor development materials and normal language development materials

Activities for the classroom

"Teaching Strategies for Working With Young Children Prenatally Exposed to Drugs/Alcohol" Los Angeles Unified School District

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NAPARE paper.
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TODAY'S CHALLENGE:
TEACHING STRATEGIES FOR WORKING WITH YOUNG CHILDREN AT RISK
DUE TO PRE-NATAL SUBSTANCE EXPOSURE
JULY, 1990

LOS ANGELES UNIFIED SCHOOL DISTRICT
Division of Special Education
Pre-Natally Exposed to Drugs (PED) Program

FOREWORD

The purpose of this booklet, Today's Challenge: "Teaching Strategies for Working with Young Children at Risk Due to Pre-Natal Substance Exposure" is to provide guidelines for the adaptation of preschool primary programs to serve these children.

We gained our knowledge of these children by looking at them in an intensive specialized setting. One of the things we have become convinced of is that these children should not be grouped together solely on the basis of the prenatal substance exposure.

The strategies are organized in the areas of learning, play, social/emotional, communication, motor development and home/school partnership. The strategies in each area follow a description of normal development and behaviors that place children at risk.

The strategies have been adapted with permission from the Child Development Subcommittee Report, California Foster Care Network, Children's Research Institute of California.

This booklet is based on a review of the literature as well as the observations and experiences of the contributors most of whom have worked with the PED Program for three years. Because the educational treatment of children exposed to drugs and/or alcohol is a relatively new field, the booklet cannot reflect research or data comparisons in this area.

Following in-services, it is hoped that staff will use their knowledge and experience and adapt the teaching strategies as needed to meet the individual needs of children.

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I. OVERVIEW

A. Statement of Problem

There is mounting concern at the rising incidence in the population of children who are born prenatally exposed to drugs/alcohol. The National Institute for Drug Abuse reports one out of ten pregnant mothers uses or has used drugs during pregnancy. With 500,000 children born in California each year, the total impact of prenatal drug exposure on society's ability to provide medical, social and educational services has not yet been felt; the child who has been prenatally exposed to drugs/alcohol is at risk for developmental, behavioral, psychosocial and learning problems. Schools must continue to prepare to meet the educational needs of these children.

B. Characteristics of Children Prenatally Exposed to Drugs/Alcohol

There is no "typical profile" of a drug exposed child; each child must be educated as an individual with particular strengths and vulnerabilities. Because the effects of prenatal drugs/alcohol use on children are varied, the continuum of impairment can range from minimal symptomology to severe impairment in all areas of the child's development. Characteristic behaviors include a heightened response to internal and external stimuli, irritability, agitation, tremors, hyperactivity, speech and language delays, poor task organization, processing difficulties, problems related to attachment and separation, poor social and play skills, and motor delays.

While organic deficits caused by prenatal exposure to alcohol/drugs cannot always be remediated, and while immunity against adverse child rearing conditions cannot always be created, high quality child/family intervention services can significantly improve a child's self esteem, self-control, and ability to solve problems in the real world.

C. Description of the Prenatally Exposed to Drugs/Alcohol Program

The Los Angeles Unified School District, Division of Special Education, in cooperation with District Psychological, Health and School Mental Health Services, has created a pilot program at the Salvin Special Education Center. At present there are four classes including a transition Kindergarten class located on a regular elementary campus at 75th St. School.

Children, ages 3-6, and their families are currently being served in the pilot program. Transportation is provided for the children and they receive support from a district speech and language specialist, adaptive physical education teacher, school social worker, school psychologist, school physician and school nurse.

D. Goals of the PED Program

1. To develop a preschool program that incorporates a family focus, systematic interdisciplinary assessments, individualized programming, consistent teaching, support staff and program evaluation.
2. To develop effective strategies and provide structured learning experiences to promote the cognitive, communicative, psychosocial and motor development of children prenatally exposed to drugs/alcohol.
3. To identify preschool children who are at risk for behavioral and developmental learning problems due to prenatal drug/alcohol exposure.
4. To facilitate the successful transition of PED children to a regular education setting or to their least restrictive special education program placement.
5. To promote a better understanding of young children who have been prenatally exposed to drugs/alcohol and who are at risk for school failure.

II. PHILOSOPHY OF PROGRAM

The behaviors seen in the preschooler prenatally exposed to drugs/alcohol are the result of a constellation of risk factors resulting from possible organic damage, early insecure attachment patterns, and often ongoing environmental instability. The child is particularly vulnerable to many stresses that impact daily living. The extremes observed in a child's behavior, be it passivity to hyperactivity, apathy to aggression, indiscriminate trust to extreme fear and suspicion, must be understood in the context of each child's experience.

Research has shown that the progress of a child at risk is more favorable when the child is placed in a predictable, secure and stable environment. Intervention programs for the child must include the development of protective environments with defined structure, expectations and boundaries, as well as the provision of on-going

nurturing and support. Early positive, responsive care is crucial for the child's emotional and cognitive well being. Establishing a strong attachment with each child through understanding and acceptance is a teacher's major priority. Only in the context of a good attachment will a child's true potential be realized.

Intervention strategies must attempt to counteract prenatal risk factors and stressful life events. To accomplish this the teacher must build in protective factors within the classroom environment and provide facilitative ways for young children to cope appropriately with stress. Self-esteem, self-control and problem solving mastery are best achieved when protective factors are coupled with a facilitative approach in the acquisition of better coping skills. These protective and facilitative processes are similar to those built into any good preschool program, but because children pre-natally exposed to drugs/alcohol are more vulnerable, these program components are essential.

The following are protective factors to be built into a classroom for at risk children:

A. Curriculum

Curriculum is viewed as the children's total experience from the time they leave home until they return.

Children at risk need a developmentally appropriate curriculum which promotes, "learning by doing" through interaction, exploration, and play; in a context that is interesting and relevant.

An approach which provides active learning, concrete experiences, decision making and problem solving encourages competency and self-esteem and promotes motivation for new learning.

B. Play

Children at risk need extended periods of play. Through play a child learns to learn; to explore and manipulate the environment, to cope with the perplexities of life experiences; to express feelings, and to become symbolic thinkers. Adults can facilitate a child's play by furnishing props, making suggestions and asking questions to clarify and elaborate. When adults participate in a child's play, by sharing and encouraging, it reassures the child that the play is valid and meaningful and that the solutions reached during play are important.

C. Adult:Child Ratio

Children at risk need a setting in which the adult-child ratio is high enough to promote attachment, predictability, nurturing and on-going assistance in learning appropriate coping styles.

D. Flexible Room Environment

Children at risk need a setting in which classroom materials and equipment can be removed, to reduce stimuli, or added, to enrich the activity.

E. Transition Time Plans

Children at risk need a setting in which transition time is seen as an activity in and of itself and as such has a beginning, middle and end. Special preparation is given to transition time, recognizing that it is one of the best times of the day to teach the child how to prepare for and cope with change and ambivalence.

F. Routines & Rituals

Children at risk need a setting which is predictable. Providing continuity and reliability through routines and rituals and scheduling activities to occur in a predictable order over time strengthens a child's self-control and sense of mastery over the environment.

Not all professionals (speech and language therapist, psychologist, social worker, etc.) come into the classroom weekly to interact with the children. These adults should develop a routine for reintroducing themselves and predicting for the children when they will appear again. Consistent personnel who help children understand the visiting adult's schedule enhance a child's sense of security.

G. Classroom Rules

Children at risk need a setting in which the number of explicitly stated rules are limited. By limiting classroom rules, children are encouraged to explore and actively engage in their social and physical environment. While it is possible to teach specific objectives by relying on rules to control the child, it may be at the expense of the child's intrinsic motivation, problem solving capacity and self-mastery.

H. Observation & Assessments

Children at risk need a comprehensive assessment. While monitoring skill acquisition in the areas of language, social/emotional, cognitive and motor development is necessary, it does not constitute an adequate assessment of the child's progress. The manner in which the child uses these skills during play, at transition time and while engaged in self-help activities is equally important. Close observation of a child's behavior at these times allows for the understanding of how the child experiences stress, relieves tension, copes with obstacles and reacts to change. It provides valuable information on how the child uses peers and adults to meet needs and solve problems.

The following are facilitative processes to be built into a classroom for children prenatally exposed to drugs.

A. Respect

Children at risk need a setting composed of nurturing adults who are respectful of children's work and play space and who do not make unrealistic demands nor unpredictably appear or disappear.

B. Attachment

Children at risk need a teacher who accepts the child with history of both positive and negative experiences. It is assumed that as a high risk child there may be a history of poor attachments and lack of trust. The degree to which a child comes to trust the world depends, upon the extent to which the caregiver can respond to the developing child's special needs. When care is inconsistent, inadequate or rejecting it fosters mistrust, fear, suspicion, apathy or anger towards the world and people in particular. These feelings will carry through to later stages of development.

C. Feelings

Children at risk need a teacher who accepts that children have negative and positive feelings. Feelings are real, important and legitimate. Children behave and misbehave for a reason, even if it cannot be figured out. In responding to a child's misbehavior, the first priority should be to acknowledge what the child seems to want before dealing with the misbehavior. Doing so allows the child to recognize that feelings are real and valid. Being understood facilitates self esteem and promotes a willingness to function within prescribed limits.

Different children respond to stress (internal or external) in different ways. Individual children show different responses to the same stressful events on different days. Teachers need to develop a sensitivity to the particular meaning different stressors have for the individual child and not have a predetermined set of expectations for or responses to child behavior.

D. Mutual Discussion

Children at risk need a teacher who acknowledges that children's behavior, feelings and experiences are open to mutual discussion. Talking about behavior and feelings, (done with empathy rather than judgment) validates the child's experiences and sets up an accepting atmosphere. Permission to have these feelings leads to the increased ability to distinguish between wishes and fantasies on the one hand, and reality on the other. Verbal expression allows the child to integrate past and present events into a total experience. This integrating process leads to the child's increased ability to modulate behavior, gain self-control and express feelings.

E. Role Model

Children at risk need a teacher who understands that by establishing an individual, trusting relationship, the teacher becomes an important person, and behavior the teacher models is more likely to be imitated.

F. Peer Sensitivity

Children at risk need a teacher who realizes that a child becomes sensitive and aware of the needs and feelings of others only by repeatedly having their own needs met.

G. Decision Making

Children at risk need a teacher who recognizes that it is important that they be allowed to make decisions for themselves. Freedom to choose and to assume the responsibility for those choices gradually expands the child's physical, social, emotional and intellectual growth, promotes self-esteem, problem solving mastery and moral values.

H. Home/School Partnership

The home is recognized as an essential part of the curriculum. Facilitating parental/caregiver goals helps to establish a close working relationship between

home and school. Intervention strategies that strengthen the positive interaction between child and family increase parental confidence and competency.

I. Transdisciplinary Model

Program intervention is best achieved when all professionals concerned with the child and family are coordinated. To accomplish this successfully, time must be allotted for teachers to meet and plan with assistants and for support services of social workers, psychologists, speech and language and adaptive physical education to come together to develop a comprehensive plan to meet the special needs of the child and family.

III. TEACHING STRATEGIES

A. Learning

Learning occurs in a developmental framework. Development is an internal process in which the child is consistently organizing and reorganizing experiences within a continuum of stages. Movement through the stages is not an automatic passive activity. From birth, a child who has not been exposed to drugs/alcohol has the potential to attend and respond to stimuli and take the initiative to explore and control the environment.

Competency to perceive and explore the environment can be damaged in the child pre-natally exposed to drugs/alcohol. Concrete experiences, decision-making and problem solving within a nurturing environment as well as a positive interactive communication help to build the foundation for development. This foundation promotes self-esteem, competence and motivation for new learning.

NORMAL LEARNING DEVELOPMENT

LEARNING BEHAVIOR OF AT RISK CHILDREN

TEACHING STRATEGIES

The child:

- .learns to focus on tasks in play situations.
- .uses numerous problem solving strategies.
- .shows sustained attention in individual and small group activities.
- .develops a sense of task completion.
- .steadily progresses in the acquisition of skills.

The child:

- .may easily be distracted by sounds, people and movement.
- .may have poor visual scanning.
- .may show decreased trial and error.
- .may show decreased problem solving strategies.
- .may have decreased attention and concentration.

Teaching staff:

- .provide support and emotional reassurance.
- .reduce classroom interruptions as much as possible.
- .limit number of objects in room.
- .establish classroom routines with minimum number of transitions.
- .model alternative strategies.

NORMAL LEARNING DEVELOPMENT

- .learns to delay immediate needs and to conform to the social expectations of the classroom.
- .is able to end a preferred activity and start a teacher directed activity.
- .demonstrates sporadic/ intermittent mastery of of skills in new learning situations.
- .acquires pre-academic concepts through incidental learning.

LEARNING BEHAVIOR OF AT RISK CHILDREN

- .may show perseverative behavior in problem solving.
- .may show decreased task completion.
- .may need longer time to complete task.
- .may give up easily when confronted by problem solving situations.
- .may be easily frustrated and become irritable in problem solving situations.
- .may be unable to do task previously mastered.
- .may be unable to take turns.
- .may not remain seated in circle or at the table with the other children.
- .may withdraw from a lack of social and environmental stimulation and may learn to become non-responsive.

TEACHING STRATEGIES

- .direct child to watch another child who is using a successful strategy.
- .consider developmental level of child.
- .recognize preschoolers may need to sit in adult's lap.
- .recognize preschoolers may need to sit next to an adult.
- .use physical, concrete and verbal cues to direct or redirect child in task or activity.
- .recognize and consistently praise child's attempts and accomplishments.
- .ask child to verbalize steps of a task.
- .provide verbal cues (talk the child through task) if child is unable to verbally give steps of task.
- .provide the child with an opportunity to take turns with peers and adults.

NORMAL LEARNING DEVELOPMENT

LEARNING BEHAVIOR OF AT RISK CHILDREN

- .may not have regular play/rest cycles or patterns.
- .may become upset with changes in routine.
- .may have difficulty with changes/transitions.
- .may be unable to end or let go of preferred object or activity.
- .may demonstrate sporadic/intermittent mastery of skills over prolonged period of time.
- .may not learn incidentally.

TEACHING STRATEGIES

- .model taking turns.
- .provide attention and time to children who are behaving appropriately.
- .protect child from the over-stimulation of intrusive persons or noisy environments and from the under-stimulation of a bland social and environmental experience.
- .provide the child a schedule of play and rest activities to help develop regular patterns.
- .alert the children routinely 1-2 minutes ahead of time that the activity will soon be over.
- .talk about the next activity before entering into the activity.
- .allow adequate time for the transition activity.
- .guide the child through the transition and into the next activity.
- .recognize stressors in child's environment and attempt to minimize them.

B. PLAY

Play is the area where a child integrates experiences with communication, social/emotional and motor skills. Through play, a child can learn to understand self and relationships to others and the world. As a child grows and matures play involves increased communication skills, attention, concentration and concept development. Strategies for play are important because a child prenatally exposed to drugs/alcohol is at risk for poor play skills.

NORMAL PLAY DEVELOPMENT

The child:

- .learns to organize own play.
- .can independently select materials and focus on them in an appropriate manner.
- .engages in play which is functional, representational and sequential.
- .progresses from parallel to interactive play.
- .joins in play with other children.
- .initiates interactive play.
- .takes part in and initiates dramatic play.
- .is able to sequentially move through a play activity.

PLAY BEHAVIORS OF AT RISK CHILDREN

The child:

- .may show decreased spontaneous play with increased aimless wandering.
- .may not organize own play, appear perplexed and confused and cannot select materials and focus adaptively.
- .may be easily overstimulated by too many things and people and by too much noise, movement and excitement.
- .may show delay, discontinuity and disorder in representational play.
- .may have difficulty joining others in play.
- .may engage in perseverative play.

TEACHING STRATEGIES

Teaching staff:

- .give child toys and/or areas in the classroom that are child's alone, and do not have to be shared.
- .recognize that the child may not have had consistent play objects in child's environment.
- .find out what is available for the child in child's home.
- .decrease/regulate amount of toys for child.
- .will respond to and follow the child's lead in play.
- .will model toy choices for child with correct verbal cues.

NORMAL PLAY DEVELOPMENT

PLAY BEHAVIORS OF AT RISK CHILDREN

- .may not initiate appropriate interactive play.
- .may not initiate dramatic play.

TEACHING STRATEGIES

- .verbally and physically models play with toys.
- .provide opportunities for the child to play interactively in a safe environment with the adult available for assistance and reassurance.
- .provide child with opportunities to take turns with peers and adults.
- .provide time to model interactive play.
- .provide child with support and encouragement during play.
- .initiate and models dramatic play with child.
- .respond to child when child initiates dramatic play by verbal responses or by playing with the child.

C. SOCIAL/EMOTIONAL

When interactions between the drug/alcohol exposed infant and caregivers result in poor attachment, rejecting or inconsistent care, the child is at greater risk for developing mistrust, suspicion and fear. These attitudes may carry through to later stages of development and manifest themselves behaviorally. Exaggerated behavior patterns are often the way a child copes with a situation that is overwhelming. Each child must be made to feel emotionally safe to attempt new learning. It is important to establish a responsive, nurturing environment conducive to active learning in which the child may build a positive self-concept.

<u>NORMAL SOCIAL/EMOTIONAL DEVELOPMENT</u>	<u>SOCIAL/EMOTIONAL BEHAVIOR OF AT RISK CHILDREN</u>	<u>TEACHING STRATEGIES</u>
The child:	The child:	Teaching staff:
.develops and maintains healthy attachments.	.may not use adults for comfort, play, approval or object attainment.	.provide opportunities for contact, mutual touch and smiling throughout the day.
.separates from parent when trust has been established.	.may go from one to another showing no preference for a particular adult.	.respond to specific needs of child with predictability and regularity.
.learns to look for and respond to adult approval.	.may not look to adult for recognition of a job well done.	.need to address child by name, elicit eye contact and/or touch child before giving verbal command.
.learns to respond to gestural/verbal praise and setting of limits by teacher.	.may display negative feelings about self and abilities.	.talk child through to consequence of child's action.
.forms attachment to teacher.	.may not respond in any way to verbal praise from adult.	.provide the child with explicitly consistent limits of behavior.
.learns to socially signal desires and needs.	.may ignore verbal/gestural limit setting.	
.learns to interpret and respond to social cues of adults.		

NORMAL SOCIAL/EMOTIONAL
DEVELOPMENT

- .learns to read and respond to social cues of peers.
- .shows broad range of emotions, including pleasure, anger, fear, curiosity and assertiveness.
- .shows a balance in emotions.
- .learns to regulate own inner-state.
- .responds to emotions of others.
- .learns to develop an independent sense of self and responsible behavior resulting in self-esteem.
- .develops a strong self-interest.

SOCIAL/EMOTIONAL BEHAVIOR
OF AT RISK CHILDREN

- .may show decreased compliance with routine simple commands.
- .may show indiscriminate attachment to all adults.
- .may display overly compliant behavior towards adults and peers.
- .may not signal desires by giving eye contact, gesturing or vocalizing.
- .may not be able to read teacher's cue/look.
- .may show a restricted range of emotion.
 - overreacts to "no" by total withdrawal.
 - rarely smiles, laughs or show joy.
 - lethargy, listlessness, flat of affect.
 - clingy behavior with adult.
- .may not express/show feelings of fear, grief, worry, anger.
- .may withdraw, seem to daydream or not be there.

TEACHING STRATEGIES

- .take every opportunity to develop teacher child relations.
- .use close proximity and gestures.
- .respond to muted signals and gives child a verbal explanation of child's behavior.
- .move close to the child, look at the child and help the child to read teacher's cues by explaining to the child what the teacher's look, body language, or gesture means.
- .label expression of emotions so child learns to identify those emotions.
- .use books, pictures, doll play and conversation to explore and help child express a range of feelings.

NORMAL SOCIAL/EMOTIONAL
DEVELOPMENT

SOCIAL/EMOTIONAL BEHAVIOR
OF AT RISK CHILDREN

TEACHING STRATEGIES

- .may have poor inner controls/impulsive.
- .may have difficulty with modulating behavior (mood extremes, e.g., giggles turn to screams).
- .may remain clingy and dependent on teacher for decisions and daily living activities for extended periods of time.
- .may over-react to separations from primary caregiver.
- .may show some lack of self-awareness as an individual.
- .may not show concern or empathy towards others.

- .allow, identify and react to child's expression of emotions:
 - pleasure -curiosity
 - protest -dependency
 - excitement -love
 - anger -fear
 - self-assertion
- .model full range of emotions for child.
- .communicate with caregiver and find out if there has been an upset in the home or any change of routine in the home, any family emergency or if the child's sleeping pattern has changed.
- .assist child in gaining control by:
 - getting eye contact
 - sitting next to the child
 - verbal reassurance
 - physical comfort, i.e., teacher rubs child's back.
- .use stories, puppets and role play to develop empathy for others.

NORMAL SOCIAL/EMOTIONAL
DEVELOPMENT

SOCIAL/EMOTIONAL BEHAVIOR
OF AT RISK CHILDREN

TEACHING STRATEGIES

- .provide daily opportunity for the child to practice independent feeding, dressing, bathing, toileting and play skills with tolerance for messiness and dawdling.
- .provide child with a daily opportunity to make small decisions and limited choices in play and/or self-help activities.
- .have activities centered around the child as an individual.
- .provide spaces and objects in the classroom that are for each child (cubbies with names, personal toys from home and individual picture books).

D. Communication

The child's capacity to communicate evolves from early mother-child interaction. The development of a child's language depends on the child's ability to receive, understand, integrate and express meaningful experiences. The child learns to use gestures/words to express feelings, communicate wants and describe experiences. A child learns language best through social interaction with significant individuals and through active exploration of the environment.

<u>NORMAL COMMUNICATION DEVELOPMENT</u>	<u>COMMUNICATION BEHAVIORS OF AT RISK CHILDREN</u>	<u>TEACHING STRATEGIES</u>
The child: .is able to follow directions appropriate for his developmental level (simple commands, multiple commands). .learns to communicate simple wants and needs, name objects, expresses feelings at appropriate developmental levels and describes experiences and events. .is able to use pragmatic language. .learns to initiate appropriate interactions with peers.	The child: .may have delayed receptive and expressive language. .may be unable to follow directions that are appropriate for the child's developmental level. .may have prolonged infantile articulation at the preschool level. .may not use attained language to communicate feelings, wants and needs. .may be unable to verbalize needs, wants and fears and expresses them through behavior such as banging, stomping, and shouting. .may show listlessness, passivity, and/or lack of social awareness.	Teaching staff: .create a stable environment where child feels safe to express feelings, wants and needs. .use "hands-on" activities to reinforce the child's language. .use eye contact, give simple one step directions, and gradually increases the number of steps in a direction. .map language in the context of the activity. .provide names of people, pets, food items, body parts, objects, feelings and events in the process of conversation.

NORMAL COMMUNICATION
DEVELOPMENT

COMMUNICATION BEHAVIORS
OF AT RISK CHILDREN

TEACHING STRATEGIES

.may observe rather than
verbally engage with peers
in play.

.may inappropriately
initiate interaction with
peers by:

- hitting
- pushing
- biting
- swearing
- negative verbal remarks

.immediately respond to
beginning attempts at
verbal communication.

.investigate child's
behavior by asking child
questions to discover
what child needs, wants,
or fears.

.acknowledge the needs or
wants or fears of the
child.

.provide strategies to the
child of how to
appropriately express
child needs, wants, or
fears.

.acknowledge attempts by
child to cooperate and
interact with other
children.

.recognize negative
behavior may be a signal
of child's unmet needs.

.reflect child's
feelings.

.verbally direct child's
behavior.

NORMAL COMMUNICATION
DEVELOPMENT

COMMUNICATION BEHAVIORS
OF AT RISK CHILDREN

TEACHING STRATEGIES

- .verbally cue child's attempts toward adaptive behavior.
- .ignore inconsequential verbal behavior.
- .verbalize expected behaviors.
- .redirect behavior.
- .remove child and help child calm self.
- .provide child verbal language to use with each other.
- .will intercede with extra support for child who has used best developmental skills to resolve conflict without success.
- .set consistent limits on inappropriate behavior, but allows for expression of feelings.
- .provide time to talk with child about emotions.

E. MOTOR

Motor and spatial development stems from the interplay of a number of factors beginning prenatally and continuing through early childhood. Any major interferences along this continuum can result in motor/spatial impairment. As a result of prenatal exposure to drugs/alcohol, the child may exhibit varying degrees of fine, gross motor and spatial relationship delays that are neurologically based. A child's sense of autonomy over the environment is enhanced when given the opportunity to experiment and discover effective approaches in mastering activities.

<u>NORMAL MOTOR/SPATIAL DEVELOPMENT</u>	<u>MOTOR/SPATIAL BEHAVIOR OF AT RISK CHILDREN</u>	<u>TEACHING STRATEGIES</u>
The child:	The child:	Teaching staff:
.has awareness of child's body placement in relationship to the environment.	.may trip or stumble without apparent cause.	.verbally remind child of obstacles.
.has age appropriate gross motor skills.	.may have difficulty with gross motor skills (e.g., swinging, climbing, throwing, catching, jumping, running and balancing).	.guide child through motor activities that emphasize the skills of rhythm, balance, and coordination.
.has awareness of space relationships among objects in relationship to self.	.may walk into stationary or moving objects.	.model and guide child in learning to control child's body through songs, games, and play.
.has awareness of space relationship among objects in relationship to each other.	.may move too close or too far away from another object.	.provide child with opportunities to experience spatial relationship through motor mazes, outdoor play and indoor play.
.is able to manipulate objects at an age appropriate level.	.may show splaying of fingers, immature grasping skills.	
	.may have difficulty manipulating objects (stacking, stringing, cutting drawing).	.provide a variety of tactile and small motor activities (water & sand play, pegboards, puzzles, blocks, legos, etc.).

NORMAL MOTOR/SPATIAL
DEVELOPMENT

MOTOR/SPATIAL BEHAVIOR
OF AT RISK CHILDREN

TEACHING STRATEGIES

.may exhibit tremors when
stacking, stringing or
drawing.

.observe child and note
tremor occurrences and
duration and how child
compensates for tremors.

F. HOME-SCHOOL PARTNERSHIP

The home is recognized as an essential part of the curriculum. Research has indicated that early intervention programs are essential in producing long term positive results only when parents/caregivers are part of the program design. Interactions between teachers and parents/caregivers must be professional, sensitive and flexible. This relationship must be based on the expression of mutual concern and goals.

Parents of children at risk may themselves have past and/or present experiences which can compromise their ability to effectively parent their child. Factors, which may include poverty, depression, a history of child abuse/neglect, family instability and violence, history of psychiatric problems, drug abuse, etc., are taken into consideration when staff is addressing the child's needs with the parent.

Children who reside in foster homes or are placed with extended family members are particularly vulnerable to the consequences of separation, loss and poor attachments. These children require on-going support and coordinated case management plans with the goal of maximizing the child's success within the home and in the school. The emphasis on strengthening the positive interaction between caregiver and child increases the caregiver's awareness and understanding of the child's individual needs and assists in promoting feelings of confidence and competency within the caregiver. This empowerment of the caregiver will benefit the child far beyond his/her formal school program.

Having the knowledge of school/community resources and a genuine interest in the parent's well-being are essential to bridging the home-school partnership.

HEALTHY HOME ENVIRONMENT

The child:

- .has a mother who receives proper prenatal care.
- .is provided consistent, responsive primary caregiver from birth.
- .is provided predictable, safe, stable environment.

AT RISK ENVIRONMENT

The child:

- .with prenatal exposure to drugs/alcohol may:
 - be premature
 - be small for gestational age
 - go through withdrawal

TEACHING STRATEGIES

Teaching staff:

- .approach child/family history with professionalism and respect for confidentiality.
- .identify family constellation and primary caregiver.

HEALTHY HOME ENVIRONMENT

- .has regular eating and sleeping patterns.
- .will have a mother/primary caregiver who sees herself as child's first teacher.
- .is provided with established family rituals around daily living activities and special events.
- .is provided appropriate developmental activities.
- .is encouraged to express feelings.
- .is encouraged to be self-sufficient and independent.

AT RISK ENVIRONMENT

- suffer damage to gastro-intestinal endocrin, respiratory genito-urinary, cardiovascular and/or central nervous systems.
- .may have multiple home placements.
- .may have multiple caregivers.
- .may live with other young children who are at risk.
- .may be abused and neglected.
- .may receive inconsistent and intermittent nurturing.
- .may have caregiver who is emotionally unavailable.
- .may have caregiver who is overwhelmed or untrained in dealing with the child's emotional needs.
- .may be exposed to chaotic, unpredictable and unstable environments.

TEACHING STRATEGIES

- .recognize stressors in child's environment and attempt to minimize them.
- .develop relationship with the caregiver and open lines of communication with caregiver.
- .schedule ongoing visits to:
 - obtain a child's history (number of placements, medical history, family history, other agency involvement).
 - identify current interventions used by caregiver.
 - discuss observations of child's behavior and progress.
 - observe and discuss caregiver/child relationship.
 - identify parental concerns and assess family needs.
 - develop individual family service plan.
 - facilitate referral to other agencies as services are needed.
 - encourage participation in parent education classes.

HEALTHY HOME ENVIRONMENT

AT RISK ENVIRONMENT

TEACHING STRATEGIES

- .identify stressors for caregiver/child and attempt to minimize them.
- .discuss and model the importance of predictability and organization:
 - by developing a transition plan with caregiver for entering school (books, toys, expected parent attendance).
 - by establishing regular patterns of communications with home (phone calls, classroom newsletter, informal notes, notebook back and forth).
 - by anticipating, discussing and integrating events at home and school (daily routine, special events).
 - by discussing implications of prenatal exposure to drugs/alcohol (short term and long term effects).
 - by promoting an understanding of psychosocial risk factors (abuse, neglect, multiple caregivers/placements).



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January 31, 1991

Hillsborough County Public Schools
Drug Exposed Children's Committee
Tampa, Florida

To Whom It May Concern:

Thank you so much for forwarding to me a copy of "Course Outline: Strategies For Teaching Young Children Prenatally Exposed to Drugs."

I am writing on behalf of Suzanne Tansey, Linda Chin, and myself to ask permission to reproduce some or all of this information for our Project Seminar for our Master's Degree at Herbert Lehman College. We are preparing an extensive review of the literature, as well as a directory for drug users, parents, professionals, and teachers to use as a resource when dealing with "Crack Babies." We wish to include a chapter on teaching strategies for these children as they enter our school systems so that they may receive a quality education despite their beginnings.

We hope you will write us and reply to our request. Thank you for your help and again, thank you for sending the booklet to us in the first place.

Sincerely,

Karen Snyder-Spatarella
Karen Snyder-Spatarella

Linda Delapenha
Signature

LINDA DELAPENHA, SUPERVISOR
Print Name/Title
PRIMARY DIAGNOSTIC SERVICE
Chairman of DECC

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FLORIDA DEPARTMENT OF EDUCATION

Betty Castor

Commissioner of Education

December 3, 1990

Dear Hot Topic Recipient:

Enclosed please find a copy of Cocaine Babies: Florida's Substance Exposed Youth as per your request. Due to the popularity and great demand for this document, we are only able to send one copy per request. For your convenience, feel free to reproduce this booklet with the proper acknowledgements. If you have any comments or need further information concerning Cocaine Babies: Florida's Substance Exposed Youth and the impact these children will have in the classroom, please contact our office at (904) 468-7835.

Sincerely,

Daniel N. Thomas
Communications Coordinator

DT/aw

Enclosure

Tallahassee, Florida 32399

Affirmative action/equal opportunity employer

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December 14, 1990

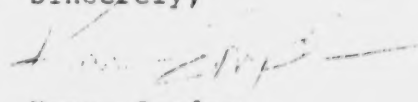
Ms. Valerie Wallace
Los Angeles Unified School District
450 North Grand Avenue
Los Angeles, CA 90012

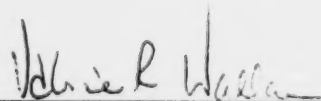
Dear Ms. Wallace:

On behalf of Linda Chin, Suzanne Tansey, and myself, I wanted to thank you very much for sending me a copy of "Today's Challenge: Teaching Strategies for Working with Young Children At Risk Due to Pre-Natal Substance Exposure" (July 1990). I was wondering if my colleagues and I may reproduce any or all of these strategies for our research project seminar on Crack-Exposed Children for our Masters Degree at Herbert Lehman College, Bronx, New York?

Please let me know if this is possible. Thank you again for your time and efforts.

Sincerely,


Karen Snyder
900-13 Coop City Blvd.
Bronx, NY 10475


Ms. Valerie Wallace

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